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THE INNOVATION PROCESS AND COMMAND CONSULTATION IN THE UNITED STATES ARMY

FINAL REPORT

by

Paul Brenner

June 1980

Supported by

US Army Medical Research and Development Command
Fort Detrick, Frederick, MD 21701

Grant No. DAMD17-74-G-9394

Yeshiva University
New York, NY

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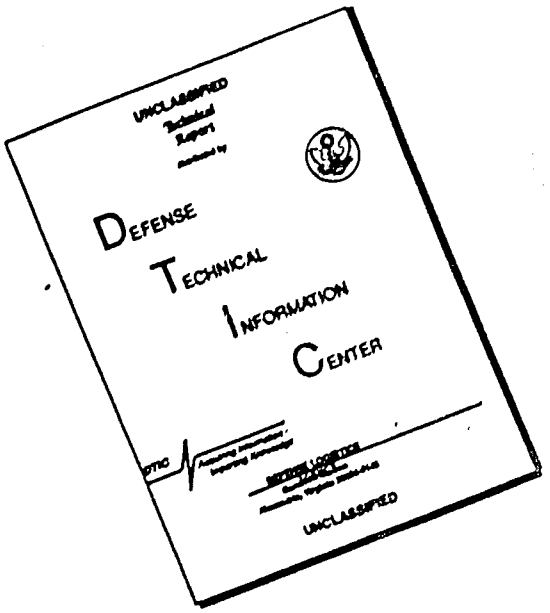

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SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

REPORT DOCUMENTATION PAGE	READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER	2. GOVT ACCESSION NO. AD-A111 707	3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle) THE INNOVATION PROCESS AND COMMAND CONSULTATION IN THE UNITED STATES ARMY*	5. TYPE OF REPORT & PERIOD COVERED Final Report (1 May 74-31 June 80)
	6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s) Paul Brenner	8. CONTRACT OR GRANT NUMBER(s) DAMD17-74-G-9394
9. PERFORMING ORGANIZATION NAME AND ADDRESS Yeshiva University New York, NY	10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS 62758A.3A162758A23.00.001
11. CONTROLLING OFFICE NAME AND ADDRESS US Army Medical Research and Development Command Fort Detrick, Frederick, MD 21701	12. REPORT DATE June 1980
	13. NUMBER OF PAGES 299
14. MONITORING AGENCY NAME & ADDRESS(if different from Controlling Office)	15. SECURITY CLASS. (of this report) Unclassified
	15a. DECLASSIFICATION/DOWNGRADING SCHEDULE

16. DISTRIBUTION STATEMENT (of this Report)

Approved for public release; distribution unlimited

17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report)

18. SUPPLEMENTARY NOTES

*The body of this report is the thesis entitled "Command Consultation: A Case Study of the Innovation Process in the US Army." The thesis was submitted in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, in the Wurzweiler School of Social Work, Yeshiva University.

19. KEY WORDS (Continue on reverse side if necessary and identify by block number)

INNOVATION, CHANGE, CONSULTATION, MENTAL HEALTH CONSULTATION, MANAGEMENT OF AN INNOVATION, SOCIAL WORKERS AND INNOVATION, PRIMARY PREVENTION; SOCIAL WORKERS AND CONSULTATION PROCESS

20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

The purpose of this research was to study the process by which innovation is introduced, developed and managed. Because of the scope of this task, the issue was explored within the more manageable context of a single case illustration. The sample selected was command consultation (CC), an innovative service function in the US Army's Mental Hygiene program.

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FOREWORD

THE INNOVATION PROCESS AND COMMAND CONSULTATION IN THE UNITED STATES ARMY*

BY

Paul F. Brenner

ABSTRACT

The purpose of this research was to gain an increased understanding of the processes by which innovation is introduced, developed and managed. Because of the scope of this task, the issue was explored within the more manageable context of a single case illustration. The example selected was command consultation, an innovative service function mandated to practitioners in the U.S. Army's Mental Hygiene Consultation Service.

Command consultation, as its name explicitly states, is a consultation service to commanders, rather than a treatment service to the individually impaired soldier. Command consultation was widely acclaimed to be worthwhile, and for the past thirty years, has been presented as a viable strategy for assisting commanders in dealing with dysfunctional soldiers. However, the successful implementation of the process never matched the widespread acclaim that it received from Army social workers, psychologists, and psychiatrists. This study dealt with the incongruity of command consultation's far reaching, stated appeal to practitioners and its historical record of unsuccessful

*The body of this report is the thesis entitled "COMMAND CONSULTATION: A Case Study of the Innovation Process in the U.S. Army." The thesis was submitted in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, in the Wurzweiler School of Social Work, Yeshiva University.

implementation. Accordingly, the primary interest of this study was exploring the adoption and diffusion process of command consultation. The underlying objective was to illustrate the more widespread problem of how innovations in general may gain acceptance and spread or how they may be rejected and fade out of existence.

The research methodology focused on the history and events surrounding the development of command consultation. A grounded theory approach was utilized to develop concepts and process information about command consultation directly from those individuals who had knowledge of its background and experience with its use. A literature search was conducted and a preliminary, exploratory study was undertaken consisting of informal inquiries, phone calls, correspondence, cassette tape recordings, personal interviews, and a pilot survey. After assessing the preliminary data, a full scale study was initiated. Screening procedures were used to identify a sample of Army social workers who were the early innovators and practitioners in the command consultation movement. The procedures yielded a sample of 163 informed witnesses who were included in the full scale study.

Statistical procedures used to analyze the data included content analysis, measures of central tendency, frequency distributions, cross-tabulations, and factor analysis.

Among the major findings, respondents reported high levels of individual involvement, success and satisfaction with their own use of command consultation; however, they perceived that the involvement of their colleagues was very limited. Respondents also agreed that the ways in which they learned about command consultation were largely informal, sporadic, and experiential in the absence of a formal, systematic approach.

Additional findings dealt with factors which interfered most strongly with the practice of command consultation. These factors were (1) the limited experience of mental health personnel, (2) the lack of continuity of the process resulting from rotations of duty, reassignments, etc., (3) ideological commitment of mental health professionals to individuals rather than to the organization or larger systems of the Army, (4) the lack of compatibility between command consultation and client needs, (5) the complexity of command consultation processes per se, and (6) lack of consensus about what command consultation really was.

Data also revealed that the extent to which command consultation was formally institutionalized as a mental hygiene function was quite limited. Its concepts and operational procedures were never well developed and commanders' support of the process was often lacking. An important finding which had significance for social work practice was

that the diffusion of command consultation affected and was affected by the status of social work as a profession.

In conclusion, parallels were drawn between the command consultation movement and the recently developed Organizational Effectiveness program now currently practiced in the Army. A series of recommendations and suggestions were also presented.

COMMAND CONSULTATION: A CASE STUDY OF THE INNOVATION PROCESS IN THE U.S. ARMY

by

Paul Frederick Brenner

Submitted in partial fulfillment of the
requirements for the degree of
Doctor of Social Welfare
in the Wurzweiler School of Social Work
Yeshiva University
New York

June 1980

The committee for this doctoral dissertation consisted of:

Joel G. Sacks, D.S.W., Chairman

Aaron H. Beckerman, D.S.W.

Louis Levitt, D.P.A.

DEDICATION

This research is dedicated to my wife [redacted] and to my two sons [redacted] and [redacted] They were the sustaining force that provided the love, inspiration and understanding that brought this research to fruition. My parents, [redacted] instilled within me the values and desire for knowledge which were the seeds of this study. They share equally in the dedication of this academic experience.

ACKNOWLEDGMENTS

Throughout my career as an Army social worker and during the course of this research, I was assisted by many individuals. I am grateful to the following people:

Samuel M. Goldstein, Assistant Dean and Professor of Social Work, Yeshiva University, has been my mentor for fifteen years. His initial critique on this subject was an important generating force.

Jack Blue, Colonel, U.S. Army (deceased), introduced me to the field of community consultation. This research is an outgrowth of his early guidance.

Joan H. Shapiro, Associate Professor, Sociology and Anthropology, Smith College, assisted in the early development of the theoretical framework for this investigation. Her contribution was vital in teaching me the conceptual basis of consultation.

James M. Timmens, Lt. Colonel, Chief, Equal Opportunity Office, Headquarters, Health Services Command, was most helpful as a critic of the initial pilot work. He was a source of continuing encouragement, providing relevant archival collections. These proved to be invaluable resources which contributed a rich dimension to this study.

Joseph M. Rothberg, Ph.D., Research Mathematician, Department of Psychiatry, Walter Reed Army Institute of Research, deserves special recognition for his unrelenting interest and encouragement through the final phases of this work. He generously contributed time, scholarly advice, and was of great assistance in this research.

Joel G. Sacks, D.S.W., Associate Professor of Social Work and Chairman of the Doctoral Program, Yeshiva University, was my devoted advisor and committee chairman. As my major professor, he patiently and persistently shared his deep knowledge of research methodology and guided this investigation.

Special appreciation is extended to Dr. Louis Levitt and Dr. Aaron H. Beckerman, Associate Professors, who were official members of the dissertation committee. I also wish to thank other past and present members of the Yeshiva University social work faculty: Dean Lloyd Setleis, the late Dean William A. Rosenthal, Dr. Solomon H. Green, Dr. Charles S. Levy, Dr. Esther Lentschner, and Dr. Saul Hoffstein. Among my former student associates and colleagues, Dr. Paul A. D'Oronzio and Dr. Catherine P. Papell deserve recognition for their suggestions and support.

The U.S. Army Medical Research and Development command provided a supporting grant for this study. Their recognition of the importance of this subject and their financial assistance is graciously acknowledged.

The contributions of the participants in this study exceeded all expectations. Numerous individuals spent hours recounting their experiences and putting their memories into writing. Many participants prepared cassette tape recordings while others mailed papers, pictures, conference collections, and other mementos of their work as Army social work officers. I wish to thank all the participants for their efforts on my behalf.

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CHAPTER I

THE RESEARCH PROBLEM AND ITS THEORETICAL FRAMEWORK

> What we contribute contains by definition the very essence of the discoveries of our predecessors. This transmission to the succeeding generations of basic constants—so obvious in the scientific disciplines—is hardly recognized in the circle of the arts. As a result the forming of a true style of the present suffers.
>
> .....Victor Vasserely[1]

Scope and Purpose

The purpose of this research is to gain an increased understanding of the processes by which innovation is introduced, developed, and managed. Because of the scope of this task, the issue needs to be explored within the more manageable context of a single case illustration. The example selected is called command consultation, an innovative service function mandated to practitioners in the United States Army's Mental Hygiene Consultation Service (MHCS). Command consultation has been practiced in varying degrees for more than thirty years in the MHCS, and it has come to be widely valued and highly regarded by those military practitioners familiar

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[1]Victor Vasserely, Vasserely 3 (Neuchatel, Switzerland: Du Griffon, 1974).

with it. Despite the relatively broad base of expressed support that it has received, command consultation has neither been systematically operationalized nor well established in any one location for any consistent span of time. This study will attempt to account for how command consultation failed to become institutionalized in the MHCS despite the promise of its ideas and the wide acclaim it received.

Throughout this study, the primary interest will be in the adoption and diffusion process of command consultation. The underlying objective is to illustrate the more widespread problem of how innovations and social movements in general may gain acceptance and spread or how they may be rejected and fade out of existence. The usefulness of such an endeavor is related to the dynamic progress of twentieth century man, particularly in the Western World. The reality of a constant and rapidly changing environment makes it desireable to understand the broad concepts of innovative change so that there may be some level of control in guiding the course of events. The history of knowledge readily points to the movement that man has made in the conception of ideologies, philosophies, and theoretical constructs. Such progress illustrates the extent to which man has taken control over the wide parameters of his universe. Moreover, the refinement of man's intellectual capacities has enabled him to exercise his will in producing complex technological inventions and creative, ideational innovation.

Definition and Rationale

Command consultation is a procedure in which Army psychiatrists, social workers, and psychologists intercede within the command structure in helping it achieve more effective utilization of its resources so that improved functioning might be obtained for the individual, the group, and/or the organization. As Glass has commented, command consultation is a program of primary prevention within the Army where the focus is on eliminating ineffectiveness or dysfunction before it has a chance to reveal itself.[2] The practice of command consultation normally takes place within the environment of the consultee who is free to accept or reject options which the consultant offers. The consultant does not have responsibility for direct action regarding the presenting difficulty nor is he responsible for the actions of the consultee. Command consultation may take on a variety of forms such as "program consultation, case consultation, administrative consultation, unit group consultation, or educational consultation."

The process of command consultation represents a dramatic departure from traditional models of mental health intervention where the primary focus was on directing care to the individual. Counseling and therapy within the clinical setting were the most characteristic modes of aiding emotionally troubled soldiers. The establishment of the command

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[2]Albert J. Glass, et al., "The Current Status of Army Psychiatry," The American Journal of Psychiatry 117 (February 1961): 673-683.

consultation movement introduced a new and dynamic approach for enabling psychiatrists, social workers, and psychologists to combat social and emotional disturbance of soldiers.

A program that parallels command consultation exists in the civilian community. Lamb, Heath, and Downing describe the practice of consultation in this sphere:

> We believe that community mental health should utilize its limited manpower in a way that will best meet the needs of a total population and not focus on a selected "motivated few." This means providing service to all categories of patients, including those who are often regarded by mental health professionals as unattractive to treat, and extensively using mental health consultation to facilitate the work of caregivers in the community who are not mental health professionals.
>
> The indirect or preventive services are accorded a high proprity. These services do not involve clinical transactions with identified patients, but rather include the activities of mental health professionals as they work with presumably healthy individuals or organizations to expand their potential for the prevention of mental illness or the promotion of mental health . . . . Included in the indirect services are mental health consultation, community organization, and mental health education.[3]

The way consultation has been conceptualized and practiced in the civilian community is similar to Maillet's explanation of command consultation in the Army.

> The MHCS is ideally depicted as an instrumentality through which three helping professions—psychiatry, social work, and clinical psychology—lend their expertise to community caretakers, <u>especially commanders</u>,

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[3]H. Richard Lamb, Don Heath, and Joseph Downing, eds., <u>Handbook of Community Mental Health</u> (n.p.: Jossey-Bass, Inc., 1969), p. 9.

> through consultative service, in the interest of prevention and improved management of a broad range of human relations problems which impede effective military performance of individual soldiers and the human groups into which they are organized.[4]

Maillet's operational definition succinctly characterizes the command consultation program. Since its inception, this basic view of command consultation has been highly regarded by the majority of mental health practitioners, and it has been considered theoretically and practically sound. Army social workers have expressed virtual unanimity in recognizing the potential worth of such an approach. Yet, in spite of widely expressed favor, command consultation has not attained optimal or consistent integration within the MHCS. Practitioners by and large are generally reluctant to function in the consultation role. Workers tend to describe their work as being consultative, but in fact, close examination of actual practice shows that there is no significant activity in this area. These issues will subsequently be explored in detail, and evidence will be presented to support these assertions.

The overall purpose of this study will be to focus upon the reasons behind the discrepancy between widely expressed acceptance of command consultation and the limited extent to which it has been actually implemented. The intent

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[4]Edward L. Maillet, "A Study of the Readiness of Troop Commanders to Use the Services of the Army Mental Hygiene Consultation Service" (D.S.W. dissertation, The Catholic University of America, 1966), pp. 32-33.

of this investigation will be to examine the process by which this particular innovation effort was introduced, developed, and managed. The analysis will descriptively focus on command consultation as a social movement that spanned three decades. Particular attention will be devoted to the complex pressures and events that led this innovation through its life-cycle.

Innovation and Diffusion: A Process of Social Adaptation

Innovation is here defined as the conception or development of new ideas, activities, or objects; it is an "act of creative imagination."[5] Diffusion, very simply, is the process by which a specific innovation spreads throughout a social system or culture.[6]

Katz, Levin, and Hamilton view the diffusion of an innovation as a process of social adaptation.[7] They characterize the process of diffusion as the "(1) 'acceptance,' (2) over 'time,' (3) of some specific 'item'—an idea or practice, (4) by individuals, groups or other 'adopting units,' linked (5) to specific 'channels' of communication, (6) to a 'social structure,' and (7) to a given system of values, or 'culture.'" Implicit within this overview is the idea that

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[5]Alden Whitman, "Inventors Invent, but the Question is How?" The New York Times, 24 February 1974.

[6]Robert Heine-Geldern, "Diffusion," in International Encyclopedia of the Social Sciences, ed. David L. Sills (New York: Macmillan Co. and the Free Press), 4: 169.

[7]Elihu Katz, Martin L. Levin, and Herbert Hamilton, "Traditions of Research on the Diffusion of Innovation," American Sociological Review 28 (1963): 240.

the total social context within which an innovation derives plays an important role in determining its outcome. The extent of its importance may actually surpass the intrinsic worth of the innovation itself. For example, the benefit that has accrued from the use of flouridated water in reducing tooth decay is well documented. Yet, numerous communities stiffly oppose its use in spite of the statistically proven value.

A problem of the social adaptation of innovations is that complex social conditions often confound the introduction of new ideas or inventions. What may initially appear as an important innovation, one with all the promise of substantially improving the human condition, may often become muted by a relatively insignificant, unanticipated situation. Conversely, an apparently obscure idea may gain unprecedented recognition and acceptance exceeding all original expectations. This phenomenon of the social adaptation of innovation needs to be understood so that realistic planning may accompany the dissemination of new ideas.

The parallel between social innovation and social movement is an implicit element in Armand Mauss's theoretical formulation where he takes the unorthodox position that social problems actually emanate out of social movements. Usually, it is natural to think that social problems stimulate social movements or evoke innovative attempts for resolving difficulties. Quite the contrary, Mauss proposes that social

conditions in and of themselves are not inherently troublesome or problematic.

> No social condition, however deplorable or intolerable it may seem to social scientists or social critics, is inherently problematic. It is made a problem by the entrepreneurship of various interests groups, which succeed in winning over important segments of public opinion to the support of a social movement aimed at changing that condition.[8]

This counter-intuitive notion that social movements/innovations generate social problems (rather than the reverse) suggests an alternate avenue of inquiry into social adaptation; an approach that focuses on how special interest groups direct change according to their own "level of consensual reality: formal and informal."[9] Moreover, Berger and Luckmann have formulated the concept that "reality is socially constructed" by common people so that their reality is congruent with daily events of everyday life situations. So long as stability is maintained and expectations are realized, contentment and acceptance of one's "social construction of reality" will be maintained.[10] However, if this reality begins to limit or interfere with the natural flow of everyday life, then social conditions become altered and people become more open to the possibilities of new realities.

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[8]Armand L. Mauss, Social Problems as Social Movements (New York: J. B. Lippincott Co., 1975), p. xvi.

[9]Ibid., p. 11.

[10]Peter L. Berger and Thomas Luckmann, The Social Construction of Reality (Garden City, N. Y.: Doubleday & Co., 1967), p. 19.

Hence, innovators or social movement coordinators emerge in the larger societal or organizational scheme to construct a new or different reality for settling disturbance and reinstating stability.

The state of the system at the time an innovation occurs is a factor in the adaptation or diffusion process. The system may be in a state of equilibrium where there is little need for change, it may be in a state where stability and consistency are absent, or it may be at some point along this continuum. If various parts of a system are operating in harmony, and if a relative state of overall tranquility exists, attempts to alter such conditions may be rebuffed in order to maintain the status quo. On the other hand, the system might be in a state of flux characterized by dysfunction, conflict, or great change; a state which might be amenable to innovation.

History illustrates how social, psychological, political, economic, or religious conditions may influence decisions and changes among nations of the world. We can study, as an example, the state of pre-World War II Germany. Looking back, we can see an economically depressed, psychologically insecure nation that readily accepted dramatic and radical innovational ideas that nearly transformed the fabric of all humanity. We see an entire nation opting for change, which in other times, it might have found abhorent.

Another perhaps less dramatic illustration of the search to find creative solutions to social problems took

place in the sixties with the initiation of massive community action programs. The programs were widely referred to as the "War on Poverty." At the forefront of this movement were positively intentioned professionals such as administrators and professional organizations of doctors, teachers, social workers, therapists, and counselors—individuals who faithfully believed that they were embarking on a path of significant social innovation.[11] However, what had been planned as an innovative, grass roots strategy for eliminating poverty resulted in untold disappointment, failure, and social losses for large numbers of people at a cost which ranged in the billions.[12] Considerable speculation has since been made as to what went wrong with the community action programs of the sixties,[13] but there has been a general lack of consenses in explaining why it never fully achieved the objectives which were planned for it. Nevertheless, it is known that the system accepts or rejects change depending on its state at a

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[11]Nathan Glazer, "A New Look in Social Welfare," New Society, November 1963, p. 6.

[12]Daniel P. Moynihan, Maximum Feasible Misunderstanding (New York: Free Press, 1970).

[13]Y. Hasenfeld, for example, attributes the failure of the Community Action programs to several causes: (1) Unproven ideas about the causes of poverty upon which the programs of the sixties were conceived, (2) the difficulty in overcoming organizational and administrative problems, and (3) political conflict which the programs generated. See "Organizational Dilemmas in Innovating Social Services: The Case of the Community Action Centers," Journal of Health and Social Behavior 12 (September 1974): 208-216.

particular time, and this knowledge points out the need for a carefully thought out approach when innovations are introduced.

Individuals within the system influence the overall diffusion process of an innovation. Perceptions, behaviors, levels of knowledge, attitudes, and values all contribute to determining people's receptivity toward and level of acceptance of an innovation. Because there are usually wide variations among individuals with regard to these factors, it is understandable that difficulty would occur in attempting to predict or anticipate reactions to a particular innovation. If a collective group of individuals were to share similar attitudes, behaviors, or values, it might be anticipated that an innovation would be more readily accepted than if the group of individuals had sharp differences. Interestingly, even when extensive homogeneity exists among individuals in a system, other isolated factors such as habits, mores, or vested interests of a small number of people could compromise the overall success of an attempted innovation. Sherif and Sherif discuss innovation from this perspective. They posit that tradition or established values or norms of individuals stand as major obstacles to "social movements," particularly in view of the reluctance of people to let go of their beliefs unless provided with rational alternatives.[14]

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[14]Muzafer Sherif and Carolyn Sherif, An Outline of Social Psychology (New York: Harper & Row, 1956), pp. 732-733.

Social adaptation of innovations could be viewed as a process of understanding and reconciling differences between people and social systems. Developing strategies to overcome obstacles to an innovation becomes a necessary part of a successful innovation process. One such technique could consist of motivating key individuals so that they might be more accepting of change. Accordingly, effective motivation may require that information or persuasive messages be properly transmitted throughout the system.

The use of information sources and formal communication is discussed by Mason who reports that " . . . a considerable amount of observation has established a positive relationship between relative influence (upon a prospective innovation) and (the) source of information used."[15] The process of disseminating information may follow a structured, systematic approach such as an advertising campaign, educational courses, or on-site public relations drives. Careful selection of a well planned information source could significantly facilitate the diffusion process.

Worthwhile innovations, on the other hand, may be inefficiently presented, thereby not providing the best possible opportunity for such innovations to gain acceptance. The mismanagement of change could arise out of unnecessary duplication of ideas or out of inadequate planning. In many

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[15]Robert G. Mason, "The Use of Information Sources in the Process of Adoption," Rural Sociology 29 (1964): 42.

instances, awareness of factors that result in repetitious and unacceptable change efforts can be controlled in order to better predict future rational implementation.

It is paradoxical that some innovations achieve acceptance or suffer rejection in a totally haphazard fashion. It is not always the systematically presented innovation effort that succeeds. Some innovations have fortuitously gained wide acceptance after having been regarded as useless or even detrimental. Conversely, innovations thought to have significant value have inexplicably been rejected. It is perplexing that this haphazard quality over what is accepted and what is rejected exists with certain innovations. It is a problem in the social adaptation of innovations and one of the issues of this study.

Innovation Theory

The study of innovation theory is a multi-disciplinary endeavor that includes such diverse fields as business and management, anthropology, education, agriculture, communications, sociology, and psychology. The extent of research and conceptualization in this area has been spread among these foundational fields. Because no discipline is particular has either laid claim nor has comprehensively explored the parameters of innovation, the following literature search will therefore take several of these fields of interest into consideration.

Harbans Bhola has developed a classification scheme that establishes the scope of issues related to innovation theory. The five broad categories he delineated are listed below along with a sampling of questions that he identified with each category:

> (a) CONTENT OF INNOVATIONS: What is an innovation, how is it defined, what differentiates innovation from other concepts such as change, can ideas, opinions, new knowledge be viewed as innovations or are they restricted to the familiar technological elements?
>
> (b) PHILOSOPHIC CONSIDERATIONS: Is it really within human power to plan and affect innovation, and is change self-determined or pre-determined? What are the ethical components in eliciting behavioral response of others in attempting an innovative process, what are the social and political elements relating to the desirability of the few making decisions for the majority, and should there be compulsory participation or voluntary acceptance of change?
>
> (c) NATURE OF INNOVATORS: Who are innovators, what kind of individuals are they, do they have unique personality characteristics, what motivates them, what are their needs, do they behave differently in large organizations as opposed to private enterprise?
>
> (d) DIFFUSION OF INNOVATIONS: How do innovations spread, what is the process through which new ideas are transmitted throughout a system, what are the leadership patterns, how do the structural and functional operations of an organization inhibit or promote the effective implementation of an innovation?
>
> (e) EVALUATION: How can innovation take place without the agreement and consent of people, how does it occur without the acknowledgement of where people are at, how does a profession get bound up into an idea, good or bad, what determines whether or not innovation is a success or failure, what do its proponents say about it, what do those affected by the innovation say about it?[16]

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[16]Harbans S. Bhola, "Innovation Research and Theory," paper prepared as pre-conference document for the Conference on Strategies for Educational Change, Ohio State University, 1965, pp. 2-4.

In studying innovation theory, Barnett, an anthropologist, defines innovation as "a thought, behavior, or thing that is new because it is qualitatively different from existing forms."[17] He sees innovation as a unique, creative process which becomes an entity in and of itself, " . . . entirely different from the properties of its individual antecedents."[18]

Purdy also emphasizes the creative quality of innovation in education. "It is innovation if within this framework, the outcome is unique, distinctive from the status quo, and is readily identifiable." Continuing, Purdy states the following:

> It is significantly innovational when the concept, the idea, the process, the media, or the tool through which the innovation is given expression has meaning to others, is accepted and approved by them, and the process for a more general implementation becomes operative.[19]

The idea that the "improvement process" is a necessary component of innovation is stressed by Enos. He states that innovation is a continuous, ongoing process of accumulating knowledge and fresh techniques; additions which provide greater substance to the original innovation.[20] Gore and Dyson, while

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[17]H. G. Barnett, Innovation: The Basis of Cultural Change (New York: McGraw-Hill, 1953), p. 7.

[18]Ibid., p. 181.

[19]Ralph Purdy, quoted in Harbans Bhola, "Innovation Research and Theory," pp. 11-12.

[20]John Enos, quoted in Bhola, ibid., p. 12.

analyzing "decision making processes," explain that innovative decisions result in uncertainty and the likelihood of uncomfortable and unfamiliar consequences.[21] Levy states that change efforts should be guided by the manner in which the worker (innovator, change agent) respects and honors the values of his clientele, and how he considers these views in his selection of action choices which will impact upon the client.[22] Finally, Wax addresses the issue of organizational innovation from the viewpoint of power theory noting that the innovator must know how to use group process, to negotiate, to understand decision making, and to know organizational factors.[23]

Rogers's interest in innovation is rooted in two central areas: (1) "Adoption Studies" that describe the manner in which innovations are accepted or rejected, and (2) "Diffusion Studies" that analyze the total process by which an innovation is communicated or spread. Rogers has classified five basic characteristics of innovation—characteristics which affect their rates of adoption by and diffusion throughout a given system:

> (a) RELATIVE ADVANTAGE is the degree to which an innovation is perceived as better than the idea it supersedes.

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[21]William J. Gore and J. W. Dyson, eds., The Making of Decisions (New York: Free Press, 1964), p. 3.

[22]Charles S. Levy, "Values and Planned Change," Social Casework 53 (1972): 488-493.

[23]John Wax, "Power Theory and Institutional Change," The Social Service Review 45 (September 1971): 274-287.

(b) COMPATIBILITY is the degree to which an innovation is perceived as consistent with the existing values, past experiences, and needs of the receivers.

(c) COMPLEXITY is the degree to which an innovation is perceived as relatively difficult to understand and use.

(d) TRIALABILITY is the degree to which an innovation may be experimented with on a limited basis.

(e) OBSERVABILITY is the degree to which the results of an innovation are visible to others.[24]

Innovations and social movements possess a developmental history and a series of stages through which they progress. Mauss suggests that social movements evolve within the context of five distinct phases and, when incorporated together, these stages constitute a total life cycle. The model suggested by Mauss serves as an important model for analysis:

(a) Incipiency: The inception of a movement or social problem occurs while it is still in what Blumer calls the "general" stage, characterized by "grouping, uncoordinated efforts . . . unorganized, with neither established leadership, nor recognized membership, and little guidance or control.[25] Such following as it has is in the form primarily of a "concerned public . . . ."

(b) Coalescence: The next stage is . . . marked by the gradual formation of . . . formal and informal organizations develop(ing) out of segments of the sympathetic public that have become the most aroused by perceived threats to the preservation or realization of their interests . . . . There may not yet be much (if any) society-wide coordination at this stage, but there will be alliances formed, ad hoc committees and caucuses springing up here and there, and some more formal associations organized at local and regional levels . . . . The movement cannot usually be stopped at this point . . . and moves steadily toward the next stage.

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[24]Everett M. Rogers and Floyd Shoemaker, Communication of Innovations: A Cross Cultural Approach, rev. ed. of former vol. entitled Diffusion of Innovations (New York: Free Press, 1971), pp. 167-168.

[25]Blumer, as quoted in Mauss, Social Problems, p. 61.

(c) Institutionalization: When the government and other traditional institutions take official notice of a problem or movement and work out a series of standard coping mechanisms to manage it, the movement is institutionalized . . . . Institutionalization . . . is accompanied by all the characteristics of a "full blown" movement: society-wide organization and coordination (unless the movement happens to deal with strictly local issues); a large base of members and resources; an extended division of labor, regular thrusts into the political process; . . . and growing respectability . . . . Thus, institutionalization means, for the movement, its period of greatest power, support and fashionability; for the society, it means taking account of the movement with a repertory of routines which have the effect of greatly increasing the co-optation element in the mix. Repression is now reserved only for the fanatics and extremists, usually very few . . . .

(d) Fragmentation: An irony in the natural history of social movements is that their very success leads to "fragmentation." (Fragmentation) occurs typically "after" a movement has enjoyed a period of success and respectability and is caused more by co-optation than by repression; that is the irony. There are several reasons for the process of fragmentation. 1) . . . the sympathetic public and active supporters have come to feel that "things have really improved" and that the threat to their vital interests has greatly subsided. This redefinition . . . causes them to turn to other (perhaps related) causes or to drop out altogether . . . . 2) Those who remain in the movement will fall to fighting among themselves over strategy and tactics for the future; some will call for continuing the original struggle until total success has been achieved; others will call for a modification of program; still others will advocate displacement of original goals altogether and a turning toward new objectives . . . . 3) Not the least of the reasons for fragmentation will be the changing requirements of leadership as the movement's earlier charisma is routinized and the rational organizer becomes more important than the charismatic ideologue.

(e) Demise: The final stage of a movement is its "demise" (and) is seldom recognized. Instead, this stage might be defined by the movement as "success," since most of its goals may have been accomplished through co-optation, or it might be defined as a temporary setback for an otherwise still vital movement.

> However the demise is defined by the movement, it is simply a "mopping up" phase for the establishment or the society.[26]

This model posited by Mauss pertains primarily to broad scale protest movement; however, the formulation may also apply to other societal or organizational change processes. Although Mauss's model suggests five clearly differentiated stages, in actuality, variations may take place and the division points between the various stages are often not particularly well differentiated. Nevertheless, the theory will serve as an appropriate tool for facilitating a clearer understanding of the emergent issues of the succeeding investigation.

Organizational theorists have studied factors that influence the extent to which innovations gain acceptance or become discarded. Noss, for example, identifies the problem of resistance as one such factor and explains that when it is present, resistance may be of great significance when attempting to successfully introduce a new idea to individuals or organizations.[27] People commonly express a desire for new ideas, inventions or styles of life, or as Morison says, " . . . are incessantly attracted to the unknown and to things as they might be."[28] Yet, movement toward such ends does not

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[26]Mauss, Social Problems, pp. 61-66.

[27]Theodore K. Noss, Resistance to Social Innovations as Found in the Literature Regarding Innovations Which Have Proved Successful (Ph.D. dissertation, University of Chicago, 1944).

[28]Elting E. Morison, "A Case Study of Innovation," Engineering and Science (Pasadena, Ca.: California Institute of Technology, April 1950).

always proceed with smooth or easy implementation. Individuals find reasons why an idea may not work or announce why a different approach would be more acceptable. External manifestations of resistance are a powerful force among people and such resistance serves to defend individuals against changes in life adjustments. Resistance reflects the ambivalence of the individual or organization toward change.

Changes often occur which evoke little or no resistance. Groups of people may frequently alter certain behaviors in order to maintain consistency with changes in a given situation. For example, if a specific meeting room were being painted, there would probably be little problem in getting group members to agree to temporarily change the location. However, if a rival organization were to assert a claim to the same room, resistance might reach a high level of expression. The question arises over what situations or conditions exist that make it difficult or simple for groups, individuals, or social systems to change behaviors, attitudes, policies, or even ideologies.

Resistance to the diffusion of innovation is motivated by a wide variety of considerations. One assumption often hastily made is that proponents of an unsuccessful innovation effort may have carried out their plan in a haphazard or inadequate manner. While this may at times be a valid factor to explain both resistance and the subsequent failure of an innovation, there is much evidence to show that widespread

rejection may occur regardless of the innovator's skills or merits of the idea. Medical practices have been broadly instituted in the past based on invalid information only to be altered after lengthy established existence. To illustrate, the reluctance to allow patients out of bed for weeks following certain surgical procedures was a practice that existed throughout hospitals for many years. This approach was followed by a dramatic change in which patients were moved out of their sick beds within hours of awakening. It is interesting that the debilitating impact of keeping patients in bed for lengthy periods of time never prevented its widespread practice. At the same time, the demonstrable value later gained from moving patients about shortly after surgery was not enough to achieve immediate, rapid, widespread application.

Attributing the cause of resistance to the innovator alone may result in a narrow view of the role that the recipient or receiver plays in the innovation process. Regardless of how well conceived a new idea may be, the recipient (whether a system or individual) may be inclined to resist. This may occur by conscious or unconscious design. The issue is commonly dramatized in relation to the always anticipated resistance that the therapist receives when engaging the client in a clinical experience. The Freudian notion that the client may actually derive gratification from his suffering leaves the therapist with the dilemma of how to overcome

a client's begrudging utilization of the insight presented to him. Often, successful diffusion of an innovation may elude even the most skilled professional despite the use of the most refined methods that may be available.

Zander discusses six conditions that contribute to the existence of resistance—conditions that hamper the diffusion process:

> (1) Resistance can be expected if the nature of the change is not made clear to the people who are going to be influenced by the change . . . .
> (2) Different people will see different meanings in the proposed change . . . .
> (3) Resistance can be expected when those influenced are caught . . . between strong forces pushing them to make the change and strong forces deterring them against making the change . . . .
> (4) Resistance may be expected to the degree that the persons influenced by the change have pressure put upon them to make it, and will be decreased to the degree that these same persons are able to have some "say" in the nature or direction of the change . . . .
> (5) Resistance may be expected if the change is made on personal grounds rather than impersonal requirements or sanctions . . . .
> (6) Resistance may be expected if the change ignores the already established institutions in the group.[29]

Awareness of the conditions that contribute to resistance are believed by Zander to serve as a basis through which an astute leader or innovator might moderate or prevent resistance from occurring:

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[29]Alvin Zander, "Resistance to Change—Its Analysis and Prevention," in The Planning of Change, eds. Warren G. Bennis, Kenneth D. Benne, and Robert Chin (New York: Holt, Rinehart & Winston, 1962), pp. 544-546.

> Resistance will be prevented to the degree that the changer helps the changees to develop their own understanding of the need for the change, and an explicit awareness of how they feel about it, and what can be done about those feelings.[30]

Occasionally, there will be circumstances where the innovator or change agent unwittingly induces justified resistance among people. Lippitt, Watson, and Westley point out that change " . . . agents are not always as perceptive or skillful as they ought to be."[31] It may not be possible for the innovator to be totally familiar with all of the needs of individuals or with the idiosyncrasies that exist in organizations or systems.

Resistance alone does not fully explain or account for the success or failure of the diffusion of an innovation. Gross, Giacquinta, and Bernstein assert that to view the problem in this manner would be overly simplistic and would fail to consider other conditions that may exist:

> (a) Organizational members who are not resistant to change or whose initial resistance to it has been overcome may encounter obstacles in their efforts to implement an innovation which, if not removed, may make it impossible for them to carry it out.
>
> (b) Individuals in organizations are in large part dependent upon their formal leaders to overcome these obstacles and they may not remove, or even be aware of these constraints.

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[30] Ibid.

[31] Ronald Lippitt, Jeanne Watson, and Bruce Westley, The Dynamics of Planned Change (New York: Harcourt, Brace & World, Inc., 1958), p. 213.

> (c) Members who are "initially" favorable toward organizational change may later "develop" a negative orientation to an innovation, and therefore be unwilling to implement it as a consequence of the barriers and frustrations they have encountered in attempting to carry it out.[32]

The idea put forth by these authors is that in order to accurately account for the process by which an innovation diffuses, a variety of organizational or systems variables needs to be considered.

Economists have analyzed the impact of projected costs and profits on the likelihood of innovation acceptance. Mansfield, for example, showed that the size of anticipated profits was a key factor in determining the rate by which innovation spreads in industrial settings. He also indicated that successful diffusion rates of a new idea were inversely related to the amounts of the capital investment required.[33]

Sayles cautions that ". . . human relations systems tend to return to previous equilibria when pressures are removed . . . (so that) it becomes essential to utilize methods of appraisal to validate that the change has become

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[32]Neal Gross, Joseph B. Giacquinta, and Marilyn Bernstein, Implementing Organizational Innovations (New York: Basic Books, Inc., 1971), pp. 10-11.

[33]E. Mansfield, "Intrafirm Rates of Diffusion of an Innovation," Review of Economics and Statistics 45 (1963): 348-359. Also see Mansfield's "Technical Change and the Rate of Imitation," Econometrica 29 (1961): 741-766 and "Entry, Gibrat's Law, Innovation, and the Growth of Firms," American Economic Review 52 (1962): 1023-1051.

stabilized.[34] Katz identifies the importance of organizational variability and innovation to provide fresh and creative additions to work conditions. He states that "the resources of people in innovation . . . are . . . vital to organizational survival and effectiveness. An organization which depends solely upon its existing blueprints of prescribed behavior is a very fragile social system."[35] These comments, while seemingly obvious, remind the reader that the initiators of a new movement may view their innovative efforts as creative and enriching, but often may forget that many of the prospective practitioners who must carry out the idea may have other perceptions. Therefore, it is essential that a continuous process of assessment be generated to insure that the dissemination of an idea is being carried out as planned.

Issues drawn for the present inquiry are (1) how do innovators assess results, (2) what is their degree of objectivity in reaching their conclusions, and (3) how do they go about conveying their ideas to others. This review of the literature presented above suggests some of the conceptual areas within which this study will be approached, and extracting the key issues out of this material will be the theoretical basis for the analysis of the problem.

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[34]Leonard R. Sayles, "The Change Process in Organizations: An Applied Anthropology Analysis," in Readings in Organization Theory, eds. Walter Hill and Douglas Egan (Boston: Allyn Bacon, Inc., 1968), p. 561.

[35]Daniel Katz and Robert Kahn, The Social Psychology of Organizations (New York: John Wiley & Sons, 1967), p. 338.

A Case History of an Innovation: Command Consultation

At the beginning of this chapter, it was explained that the purpose of this study is to increase knowledge about how innovations are transmitted and managed in society. The introductory sections were written to establish the broad context within which innovations may take place. The cultural, philosophical, and methodological elements of innovation were briefly discussed in order to convey an understanding and appreciation for the breadth of this subject. The parameters of innovation theory were shown to extend in many directions, and the concepts associated with innovation are intrinsic to many fields of endeavor. In order to make the study of the innovation process manageable, the analysis was conducted using a single case as an illustration. To repeat, the case is called "command consultation," a particular activity practiced in the Army's Mental Hygiene Consultation Service. In this report, command consultation will be the specific case used to study innovation theory.

Command consultation is one of several functions mandated to practitioners in the MHCS. The MHCS is a medical activity that provides a comprehensive program of full mental health service in order ". . . to aid command in the conservation of military manpower and in maintaining it at the highest level of efficiency through the application of sound

mental health principles . . . ."[36] Explicit in this policy directive is a sanction for practitioners in the MHCS to assume broad responsibility for individual and organizational matters that may influence both the quality of life for people and the effectiveness of the organization. The MHCS is staffed with a professional team of social workers, psychiatrists, and psychologists. Staffing also consists of a non-professional team of enlisted social work specialists or technicians. The primary concerns are with programs oriented toward prevention as originally conceptualized by Glass and his associates. Glass stated that "primary prevention" efforts positively influence a soldier's environment in order to eliminate problems before they become manifest.[37] The second approach called "secondary prevention" seeks early identification of personal dysfunction and attempts to seek resolution prior to the need for hospitalization. The third recourse for MHCS involvement is called "tertiary prevention." It is primarily supportive and rehabilitative aimed at preventing recurrence.

Several functions are suited to MHCS personnel to enable them to carry out their work. These include diagnostic, rehabilitative, consultative, research, and educational functions. Of the five, the MHCS is fundamentally committed

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[36] Army Social Work, Technical Manual 8-241 (January 1958), p. 26.

[37] Glass, et al., "The Current Status of Army Psychiatry," pp. 673-683.

to the consultation mode, and while the remaining functions all have a role in the operation of the MHCS, official directives clearly indicate that the consultative function is the optimal desired approach.[38]

Because consultation is officially cited as the focal point of service, heavy emphasis has been placed on assisting individuals in leadership positions to better understand and deal with environmental causes of problems. These leaders could include commanders, supervisors, administrators, or any other caretaker figures in an organization who may be responsible for directing and guiding people and programs. The MHCS workers' special involvement with commanders and community caretakers affords them the unique opportunity to gain a broader frame of reference regarding the impaired soldier and the overall system within which he is working.

Historical Development

The concepts and practice of command consultation developed out of the mental health movement during World War II. At that time, psychiatrists, social workers, and psychologists were recruited from their work in civilian life, and they were brought into the military where they developed mental health programs to serve the men and women in the Armed Forces.[39]

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[38] Military Psychiatry, Training Manual 8-244 (Washington, D.C.: Department of the Army HQ, 1957), p. 30.

[39] See Henry S. Maas, ed., Adventure in Mental Health (New York: Columbia University Press, 1951).

During this period, most mental health professionals who had been in the civilian community had primarily engaged in direct service oriented functions, and the specific nature of their work usually emphasized clinical treatment and diagnostic approaches. Professional terminology used by those who were entering military service for the first time revealed the characteristic orientations of most practitioners, that is, analysis, counseling, casework, treatment, therapy, etc.

The practice of psychiatry at this time was widely focused on the integration and application of analytic theories developed during the prior thirty years. Psycho-dynamic and diagnostic models of treatment were the major thrust, and compared to what is understood today, relatively little was known about community psychiatry, primary prevention, or broad social treatment objectives.

Similarly, the emphasis in social work was also directed toward a casework model of practice. The thrust of social work education was dominated by the psychiatric approach as evidenced by the high number of caseworkers and psychiatric social workers. The presence of group workers and community organizers was a rarity. In fact, Chambers stated that ". . . the vast majority of professional social workers . . ." at this time, performed the following characteristic functions: ". . . he serves, he counsels, he comforts, he reconciles, he listens, he accepts, he judges not, he plays out a

ritualistic role . . . ."[40] These highly individualized, introspective functions performed in the 1930s by the majority of social workers, contrasts against the conspicuous absence of action oriented, community directed approaches that are currently familiar. It was with this professional orientation that the majority of civilian mental health specialists were initiated into a new area of practice.

As mental health programs evolved in the military during the early 1940s, special conditions of war led many professionals to question whether or not traditional models of clinical practice best served the needs of troubled soldiers.[41] In fact, some believed that the approach of singling out individual troops for counseling and therapy could interfere with the priorities of managing the war effort. Herein was the fundamental problem that command consultation was meant to solve. It was readily apparent to many persons that misdirected efforts to deal with emotionally stressed troops could potentially jeopardize the lives of healthy troops and compromise the overall success of various military operations.

The unusually stressful conditions of combat influenced planning and decision making with regard to the development of mental health programs. The need to provide services

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[40]Clarke A. Chambers, "An Historical Perspective on Political Action VS Individualized Treatment," In Perspectives on Social Welfare, ed. Paul E. Weinberger (London: The MacMillan Co., 1969), pp. 92-93.

[41]See Bruce L. Bushard, "The US Army's Mental Hygiene Consultation Service," in Symposium on Preventive and Social Psychiatry, ed. D. Rioch (Washington, D.C., 1957).

within the context of injury and death, homesickness and fear, or anger and depression posed extreme problems and challenges. The specific nature of mental disturbances incurred by soldiers in combat varied. Some individuals presented acute, psychotic symptoms commonly described at the time as "shell shock." Troops who feinted illness were labeled "malingerers." Other soldiers displayed neurotic, dysfunctional behavior. Many mental health professionals soon began to question the efficacy of traditional models of practice because there was increasing evidence that individual clinical services no longer appeared to be a particularly effective or efficient means with which to cope with the multiplying numbers of "psychiatric casualties." This is not to suggest that old methods were deemed inadequate because of increasing numbers to be treated; the preventative nature of command consultation just made it a new method of choice.

Traditional approaches to treating problems changed dramatically when several practitioners began to empirically document the importance of socio-cultural factors, environmental stress, and the impact which these forces had in affecting a soldier's adjustment. Examples of such environmental stresses had to do with the uncertainties of military life. Loneliness, unpredictable assignments, fear, and an authoritarian atmosphere illustrate some of the commonplace phenomena of a soldier's daily existence. Freedman and Cohen identified the organization as a primary source through which

much of the stress imposed on individuals could be significantly relieved.[42]

William Menninger, former brigadier general and chief of psychiatry for the Army, emphasized the importance of preventing debilitating effects on soldiers and combat troops, particularly when exposed to the pressures and dangers of military life.

> The most important functions of military psychiatry are primarily preventive: to give counsel and advice regarding the attitude of military men toward their jobs; to minimize environmental stresses which tend to impair the efficiency of the personality; to increase environmental supports to the personality.[43]

Other mental health professionals who were responsible for evaluating soldiers affected by combat fatigue or other emotional strain found that the greater the distance these troubled individuals were withdrawn from front line duty, the greater the likelihood that they would not return to duty. Spencer and Gray discuss that treatment of soldiers in zones at some distance from combat locations drastically reduced chances for return to duty.[44] Perkins further described that troops under stress were far more likely to recuperate and

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[42]See Harry L. Freedman, "The Services of the Military Mental Hygiene Unit," American Journal of Psychiatry 100 (July 1943): 34-40.

[43]William Menninger, Psychiatry in a Troubled World (New York: Macmillan Press, 1948), p. 337.

[44]Charles Spencer and Bernard Gray, "An Approach to Mental Health Consultation Within the Military," Military Medicine 130 (July 1965): 691.

return to duty when they were interviewed in the field and when they were given brief periods of respite from the stress to which they had been subjected.[45]

The knowledge acquired during this time resulted in innovative concepts regarding methods for working with emotionally strained soldiers in the military. Guttmacher found that "prevention rather than treatment" became the chief goal of the work. He found that "the greatest good for the greatest number could be accomplished by instructing (consulting with) the officer and cadre in the general principles of mental hygiene."[46] By the time World War II terminated in 1945, an innovative preventive approach to working with the soldier in his environment became the dominant theoretical model of practice.[47]

After World War II ended, a process of large scale demobilization took place. With this major reduction in

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[45]See Marvin Perkins, "Preventive Psychiatry in World War II," Preventive Medicine in World War II, vol. 3 (Washington, D.C.: Office of the Surgeon General, Dept. of the Army, 1955), pp. 171-232.

[46]M. S. Guttmacher, "Army Consultation Services: Mental Hygiene Clinics," American Journal of Psychiatry 102 (May 1946): 741.

[47]Out of these early conceptualizations, Gerald Caplan formulated his theoretical approach to prevention and community mental health. His works were subsequently published in the sixties and have been widely referred to throughout the mental health movement in both the military and civilian communities. See An Approach to Mental Health (New York: Grune & Stratton, Inc., 1961) and Principles of Preventive Psychiatry (New York: Basic Books, 1964).

forces, the majority of mental health facilities in the military were discontinued until the onset of the Korean Conflict in 1951. This new outbreak of hostilities preceded widespread re-establishment of mental health programs, and it was again apparent that the knowledge gained in the forties was to be reflected in the practices and approaches to problems in the fifties.

> Considerably more attention in garrison settings and in the combat zone were given to factors in the soldier's environment which could impair . . . functioning and these environmental factors were incorporated in prevention and treatment programs. The effects of this new conceptual thinking in maintaining a soldier's effectiveness is perhaps most dramatically illustrated by a comparison of psychiatric combat casualty rates during World War II, the Korean War, and the Viet Nam War. In World War II the psychiatrist combat casualty rate was twenty-three percent of all those evacuated. In the Korean War it was only six percent, a rate further reduced to five percent in the Viet Nam War.[48]

Throughout the fifties and sixties, interest in the concepts of prevention broadened. During this period, social workers became particularly aware of this systems oriented,

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[48]John G. Kisel, "Command Consultation: A Practice Modality Used by Army Mental Hygiene Consultation Service Staff" (D.S.W. dissertation, The George Warren Brown School of Social Work, 1970), p. 25. Kisel's statistics are taken from Tiffany and Allerton's article entitled "Army Psychiatry in the Mid-'60s," American Journal of Psychiatry 123 (1967): 813-814. Allerton co-authored an earlier study in 1957 which presented statistical information to suggest that the expansion of the MHCS program was followed by a reduced level of disabling psychiatric illness. While Allerton's earlier study presented data which had limitations and while the reports of actual benefits to individuals treated and evaluated in the MHCS lack clarity, the trends indicated were interesting predictors of a viable preventive concept. See Allerton and Peterson, "Preventive Psychiatry—The Army's Mental Hygiene Consultation Service Program with Statistical Evaluation," American Journal of Psychiatry 113 (1957): 788-794.

problem solving approach. A series of collected papers were presented at Fort Dix, New Jersey in 1963 which reflected attempts to conceptualize principles of prevention. As a result, command consultation was implemented in order to alleviate mental health problems in the military. Baxter stressed the importance for the profession to develop a literature defining the rationale for its implementation and to provide a conceptual framework for this mode of practice.[49]

Monahan coined the term command consultation, and in 1952 he wrote about the trend to direct professional mental health services away from office visits and from the traditional emphasis placed upon individual psychopathology.[50] He set out new priorities in moving toward utilizing the individual's own strengths by redirecting mental health interventions to the primary group, i.e., unit commanders and peer associates. This consultative approach established a clear and precise method of prevention—that is, halting dysfunction within organizations and among people before it could become manifest and disruptive. And so, throughout the fifties, Monahan continued to formulate theoretical and practical

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[49]Roy Baxter, et al., "Command Consultation Service," collected papers of Fort Dix, N.J. Mental Hygiene Consultation Service, 1963 (mimeographed). See especially 'Consultant: A Conceptual Framework.'

[50]Fergus T. Monahan, "Supportive Casework in the Army Mental Hygiene Consultation Services," Social Casework 33 (November 1952): 388-392.

implications of this new practice modality that heavily emphasized environmental manipulation.[51]

The developing knowledge of command consultation was primarily conveyed to practitioners at conferences, symposiums, and short courses during the early sixties. An extensive literature was written during this period in military social work, psychiatry, and psychology—literature that was eventually catalogued and computerized into a comprehensive bibliography.[52] Today this document serves as the primary source and repository for information detailing command consultation in the military.

During the fifties and sixties, the concepts of prevention and community mental health also spread throughout the civilian sector. The Director of the National Institute of Mental Health described what he observed as parallel activities taking place within the civilian and military communities. He traced the historical emergence of the Community Mental Health Center movement and the developments in relation to the growing awareness ". . . that no mental health program could meet the needs of the people unless it

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[51]Idem, "Mental Health Consultation in Garrison," Proceedings of Short Course in Current Trends in Army Social Work (Washington, D.C.: Walter Reed Army Institute of Research, 1962).

[52]"MHCS Bibliography," Computer Support in Military Psychiatry: COMPSY, Walter Reed Army Medical Center, Washington, D.C., 1971 (mimeographed).

began to work to prevent mental illness and improve the mental health of populations as well as of individual people."[53]

Yolles, too, described the evolution of this concept during the early twentieth century and gave particular attention to the experiences gained from military psychiatry during World War II. He made note of the Health Amendments Act of 1955 which established funds for states to develop demonstration projects in mental health services, and he described the organization of the Joint Commission on Mental Illness which conducted the first nationwide study and analysis of the extent of mental illness in the United States. The Commission's final report entitled "Action for Mental Health" ". . . established the foundation upon which the national mental health program and the community mental health centers program (were) later developed."[54] With President John F. Kennedy's subsequent support of and advocacy for the Commission's recommendations, the 88th Congress enacted the Mental Retardation and Community Mental Health Centers Construction Act in 1963.[55] In order for localities to receive funding under the new act, one of the eligibility requirements

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[53]Stanley F. Yolles, "Past, Present and 1980: Trend Projections," in Progress in Community Mental Health, eds. Leopold Bellak and Harvey Barten (New York: Grune & Stratton, 1969), p. 14.

[54]Ibid., p. 11.

[55]U.S. Congress, Senate, Mental Retardation and Community Mental Health Centers Construction Act, Pub. L. 88-164, 88th Cong., 1963, S. 1567.

stated that the Community Mental Health Center had to provide "consultation and educational services." Thus, for the ". . . first time, provision of preventive services became mandatory in a publicly supported mental health program."[56]

Since the enactment of the Community Mental Health Act of 1963, numerous programs have been developed and an extensive literature has been written to describe them. The first program in the United States was established in San Mateo County, California. The study conducted, which spanned a ten-year period—1958 through 1968—, presented many of the evolutionary concepts in the work of prevention.[57]

By the late sixties, the Community Mental Health Movement gained a relatively high level of visibility in both the military and civilian sectors. The transition from "cold war" diplomacy to intense United States involvement in Viet Nam produced changes within the military that had significant effects on the delivery of mental health services. Disaffection among young soldiers resulted in high levels of drug and alcohol related problems, racial conflicts, unauthorized absences (AWOLS), draft evasion, desertion, and disobedience. The Army attempted to deal with these problems by [illegible] a diversity of new programs such as Drug and Alcohol Rehabilitation, Race Relations, and Equal Employment Opportunity.

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[56]Yolles, "Trend Projections," p. 14.

[57]The philosophy underlying this program was identified earlier in this chapter. See Lamb, Heath, and Downing, eds., Handbook, p. 3.

In order to effectively expand services, increased numbers of professional mental health staff entered the military, and by 1970, there were over three hundred social workers on active duty. Many of these individuals were recent graduates of educational programs, and because so many were newcomers to the military, it was inevitable that the low experience factor would have some impact on the conduct of command consultation. While practitioners continued to value primary prevention as an approach to mental health services, the high influx of relatively inexperienced personnel is thought to have diluted the practice of command consultation. Throughout the fifties and sixties, command consultation practice was heavily dependent on the expertise and leadership of the relatively few individuals who were familiar with it. Command consultation existed only so long as this leadership remained in a particular mental health setting. When these leaders were transferred or left the military, the command consultation effort tended to dissipate except when personnel became sufficiently stimulated and knowledgeable in the practice, or until new leaders arrived who were familiar with it. Thus, it was believed that the failure to establish a [illegible] supporting social structure for command consultation was a possible factor in explaining its development during this period of time.

Command Consultation and Its Relevance to Social Work

While the practice element of consultation has been a relatively recent development in the social work profession, the literature reveals a limited but growing interest in this arena of work. Mannino's bibliography of the literature on the consultation area of practice in social work identifies one dissertation completed in 1958 and cites a few dozen journal articles written in the late fifties and sixties.[58] The earliest article in Mannino's reference cites the work of Harriet Bartlett and Agnes Van Driel who presented two papers at the American Association of Medical Social Workers in 1942.[59] In 1968, the Social Service Review devoted an entire issue to an index of all articles published in the journal for forty years.[60] Within that time span, just one article addressed itself to consultation.[61] The essence of the remaining literature has emerged out of workshops, institutes, and forums.

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[58]Fortune V. Mannino, Consultation in Mental Health and Related Fields: Reference Guide (Chevy Chase, Md.: National Institute of Mental Health, 1969).

[59]See Bartlett and Van Driel's papers entitled "Consultation Regarding the Medical Social Program in a Hospital" and "Consultation in Relation to the Administration of Social Service Programs," two papers given at the meeting of the American Assn. of Medical Social Workers (Menasha, Wi.: George Banta Publishing Co., 1942).

[60]"Forty-Year Index," The Social Service Review 42 (March 1968).

[61]Charlotte G. Babock, "Some Observations on Consultative Experience," The Social Service Review 23 (1949): 347-357.

Werner Boehm identified prevention as one of three functions basic to social work objectives. His elaboration of "prevention, provision, and restoration" in the 1959 Curriculum Study remains as a well recognized attempt to delineate the goals of social work.[62] Following Boehm's work, an institute was held entitled "The Psychiatric Social Worker as a Consultant," and the primary purpose of that forum was to advance the concept of prevention toward a practical activity for achieving the objectives implicit within prevention. The practice for accomplishing this was "Consultation."

Gilmore has observed that "consultation in social work has become an ubiquitous activity."[63] She finds consultation to be an important "functional speciality,"[64] which has permitted a more expansive deployment of social work manpower, and has most appropriately refocused attention on preventive aspects of responding to disruptive social conditions. Green notes that social conditions are rapidly widening the need for proficient individuals and has presented the social work consultant with a significant new role.[65]

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[62]Werner W. Boehm, Objectives for the Social Work Curriculum of the Future, vol. 1 (New York: Council on Social Work Education, 1959), p. 51

[63]Mary Holmes Gilmore, "Consultation as a Social Work Activity" (Western Reserve University, January 1963), p. 1.

[64]Ibid.

[65]Rose Green, "The Consultant and the Consultation Process," Child Welfare 44 (October 1965): 425-430.

In contrast to Lydia Rapoport's efforts to conceptualize consultation for the social work profession and to describe it as a "valid social work function,"[66] other social work practitioners have cast doubt on consultation as a legitimate social work function. Consultation has been perceived as deriving from a purely administrative function bearing little resemblance to bona fide social work purposes. One response to this presently unresolved issue is suggested by Ruth Smalley who conceptualizes consultation as a valuable ". . . secondary or facilitating method used to implement some program in social work, e.g., supervision, administration, or research . . . ."[67] Still other questions have been raised about the validity of consultation in social work. In the most recent volume of the Encyclopedia of Social Work, Rapoport presents several unresolved issues of a "philosophical and ideological nature (which) concern the breadth, scope and centrality of the consultation role."[68]

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[66] Lydia Rapoport, ed., Consultation in Social Work Practice (New York: National Assn. of Social Workers, 1963), p. 18.

[67] The context of Smalley's comments are taken from her discussion of an article by E. Elizabeth Glover entitled "Social Welfare Administration: A Work Method," Child Welfare 44 (October 1965): 431-439.

[68] Lydia Rapoport, "Consultation in Social Work," Encyclopedia of Social Work (New York: National Assn. of Social Workers, 1971), p. 160.

Other Foundational Disciplines of Consultation

Numerous allied fields of practice in the social and behavioral sciences have made important advances in defining and systematizing principles of consultation. Lippitt has brought into focus the "role dimensions of change agents" from a variety of professions including psychiatry, social group work, education, trainers, organizational consultation, etc.[69] Caplan, prominent psychiatrist in the Community Mental Health field, has provided the most concerted effort in setting forth a theoretical framework for the development of mental health consultation.[70] Edgar Schein, social psychologist, has contributed a specific accounting of the principles and methods associated with the consultation process, and he explains how the consultant works within the client system in organizational development.[71] Walton analyzes confrontations and third party consultations from a business management point of view, setting forth practice principles for dealing with interorganizational conflict through a unique consultative approach.[72]

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[69]Ronald Lippitt, "Dimensions of the Consultant's Job," in The Planning of Change, eds. Bennis, Benne, and Chin (New York: Holt, Rinehart & Winston, 1962), pp. 156-162.

[70]Gerald Caplan, Principles of Preventive Psychiatry (New York: Basic Books, 1964); Concepts of Mental Health and Consultation (Washington, D.C.: U.S. Children's Bureau, 1959); and The Theory and Practice of Mental Health Consultation (New York: Basic Books, 1970).

[71]Edgar Schein, Process Consultation: Its Role in Organizational Development (Reading, Ma.: Addison-Wesley, 1969).

[72]Richard Walton, Interpersonal Peacemaking: Confrontations and Third Party Consultation (Reading, Ma.: Addison-Wesley, 1969).

The Problem

Interest in this subject originated in the investigator's prior experience in an MHCS setting where, performing in a social work role, he developed, implemented, and managed a program geared to the command consultation model. This study is based on the personal experiences and the direct impressions that the author received in doing command consultation. Initially, the researcher perceived the assigned task as having little similarity to traditional social work functions with which he was academically more familiar. This first exposure to what the candidate later came to understand as "command consultation practice" evoked feelings of uncertainty and conflict. Initially, command consultation seemed disparate with such basic social work values as the dignity and worth of the individual, acceptance, self-determination, self-actualization, etc.[73] In functioning as a consultant to commanders, the investigator felt that these values were largely subordinated against such basic military priorities as the "mission, discipline, organizational structure and function, and authoritarian formality."[74] Over time his

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[73] See Gordon Hamilton, Theory and Practice of Social Case Work (New York: Columbia University Press, 1951), pp. 3-26; and Donna McLeod and Henry Meyer, "A Study of the Values of Social Workers," in Behavioral Science for Social Workers, ed. Edwin J. Thomas (New York: Free Press, 1967).

[74] The essence of this conflict has been described by D'Oronzio who differentiated the social work profession from the profession of Arms on an ideological basis by identifying the former as "Humanitarian Liberalism" and the latter as "Ahumanitarian Conservatism." See Paul D'Oronzio's "Social Workers in the U.S. Army: Ideological Conflict and its Resolution" (D.S.W. dissertation, Yeshiva University, N.Y., 1974).

attitudes gradually changed and the conflict resolution ultimately became the basis for his own design of a field consultation program.[75] The overall process which led to the implementation of this program, the knowledge and experience which has since been integrated, and the impressions that have subsequently been formed over the years serve as the context within which the present study is based. Essentially, these impressions are based on two factors that have been delineated in the literature and identified during conversations with colleagues of the researcher who have been associated with the Army's Mental Hygiene program.

First, mental health workers have generally attested to the value of consultation since it was introduced in the Army's MHCS. The mental health professionals who developed and carried out the program articulated that command consultation had sound theoretical value and that it contained many practical advantages compared with traditional methods of clinical service. One of the first social workers to serve in the military during World War II said the following:

> . . . what you now call "consultation" was during my time the substance of professional practice. We didn't call it "command consultation" because we were more interested in doing it than in pinning a label on it . . . . You didn't find social workers chained to their desks; you found them working directly in the system with commanders.[76]

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[75]A description of this program appears in the news article entitled "Mental Hygiene: Leading A Broad Based Attack on Problem Areas of Army Life," Inside the Turret, vol. 23 (Fort Knox, Ky., April 1971).

[76]Myron Rockmore, interview, Hartford, Ct., December 6, 1973.

The high value that Rockmore placed on this "systems approach" to problem solving is a view that was shared widely among most mental health workers. Throughout ten years of experience in the Army social work program, the researcher has frequently discussed with other colleagues the relative merits of command consultation versus traditional therapeutic or diagnostic models. While there have occasionally been individuals who had some doubts, the great majority of the candidate's associates expressed virtual unanimity in recognizing the potential value and worth of the consultation approach. It is stressed that while these discussions were largely informal and did not consist of rigorous scientific analysis, the impression was conveyed that prevention and consultation were highly regarded principles of practice. Furthermore, a former social service consultant in the Surgeon General's Office expressed an essentially similar point of view regarding how he valued consultation: ". . . during periods of austere resources and high levels of organizational stress, command consultation becomes a necessity."[77]

There is a predominant consensus that the concepts of prevention and the function of command consultation came to be widely valued and highly regarded. It was frequently

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[77]Paul F. Darnauer, Colonel, Social Service Consultant to the Surgeon General, interview, February 5, 1974.

discussed at professional meetings and a published literature describing it was generated. As official recognition of and support for command consultation developed, programs emphasizing this new approach were gradually initiated at various military installations. In short, command consultation has been given extensive recognition and has received pervasive applause for its potential value in dealing with mental health and organizational situations.

Second, there is question over the extent to which practitioners actually function as consultants to commanders. As stated at the outset of this chapter, strong evidence exists to indicate that command consultation has neither been systematically operationalized nor well established in any one location for any consistent span of time. Despite the fanfare created and the tribute paid to its perceived value, there appears to be an incongruous and conspicuous absence of an ongoing program. Maillet identified the issue ten years ago:

> The first impression is that, by and large, the MHCS has been unable to implement a broad program of command consultation (underline Maillet's) . . . . Command consultation concerned with the problems of dysfunctional military groups seems to be especially rare. There is little reported MHCS experience in this area, and less documented success.[78]

A few years following Maillet's work, Kisel studied an aspect of command consultation, and in attempting to identify

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[78]Maillet, "Readiness of Troop Commanders," pp. 36-37.

a study sample, he too discovered ". . . marked variations in practice ranging from an emphasis on command consultation to a total absence of such practice."[79]

Wichlacz examined several MHCS programs, and he found that ". . . most . . . operated in a classic clinical setting." His data could not support the assertion that the MHCS widely operated under the command consultation model. Wichlacz found that many practitioners in the MHCS seemed to increasingly resist functioning as consultants and appeared to lean more toward direct practice and clinical service. Wichlacz further cited that while almost ". . . all MHCS programs were described by the personnel working at it to be primarily a consultative program . . . , in almost all cases we found no significant activity in this area."[80]

Monahan was instrumental in the development of command consultation theory, yet he also expressed doubt over the extent to which such programs actually incorporated the principles and concepts originally envisioned by the early planners and thinkers.[81] Holloway stated a similar view when he

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[79]Kisel, "Command Consultation," p. 69.

[80]Casimer Wichlacz, Captain, U.S. Army Social Work Officer, personal letter to Paul Brenner, December 6, 1972.

[81]Fergus T. Monahan, ret. Colonel, U.S. Army Social Service Consultant, Office of the Surgeon General (presently Dean, School of Social Work, Marywood College, Scranton, Pa.), interview, November 24, 1973.

suggested that the ". . . current profile of command consultation is relatively low and hardly identifiable as an ongoing systematic program."[82] With strong evidence to suggest that the practice of command consultation was basically fragmented, there was also a clear expression that a void existed with regard to formal training programs for teaching mental health practitioners about command consultation. At the 10th Annual Psychiatric Institute, Elliot Worthington, psychologist, said that there were almost no formal training programs for consultants in the Army. He stated that those who did consultation got their skills from actual job experience.[83] R. Michael Allen, former chief psychiatrist at a small Army medical center, also mentioned at this Institute that there was no training in the Army for consultation skills. In short, the majority of MHCSs in the U.S. Army do not appear to sustain the consultative component of the program with any overall consistency nor does there appear to be a formal teaching mechanism for instructing practitioners in the process.

In summary, practitioners say that they value command consultation, but at the same time there are facts to show that the function is not widely or consistently carried out. At the inception of this movement over thirty years ago, and

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[82]Harry Holloway, Colonel, Medical Corps, Walter Reed Army Institute of Research, interview, February 5, 1974.

[83]Elliot R. Worthington, "Developing Consultation Programs," paper presented at the 10th Annual Psychiatric Institute: New Directions in Mental Health, sponsored by Office of the Surgeon General and the Dept. of Psychiatry, Brooke Army Medical Center, San Antonio, Tx., Fall 1975.

throughout its development, command consultation practice was given extensive fanfare and attention. Now it is observed that the majority of mental health programs in the military simply do not sustain the consultative element of the program with any regularity. There is a great disparity between what practitioners say they value with regard to command consultation and the extent to which they actually engage in its practice. The confusion is readily apparent to those familiar with the discrepancies in practice, policy, and theory.

Directions for Research

It is the aim of this study to investigate how the inconsistency described above came about. The following research questions will provide the context for tracing the events and for explaining the process by which command consultation was introduced and managed:

1. What were perceived to be the attributes of command consultation?
2. To what extent was command consultation institutionalized throughout the Army?
3. What were the motivational forces that spurred implementation of command consultation?
4. How did the diffusion effort proceed and was it measured?

Essentially, these questions constitute an analytic model for studying the command consultation effort. A more generalized classification of these four questions indicates

three basic elements intrinsic to any innovation: (1) The idea or event itself, (2) the organization, and (3) the people who engaged in the activity. It is thought that the diffusion of command consultation was strongly affected by the viability of the process itself, by what the organizational climate would permit, and by how the practitioners themselves were affected. Understanding how each of these components interacted will be the model for analyzing the development of command consultation. Discussion of this approach will be the subject of the next chapter.

CHAPTER II

THE RESEARCH METHOD

Introduction

The central problem confronted in the research methodology was reconstructing an historical event, command consultation. The primary objective in forming the study method was to develop a systematic approach for describing the process by which command consultation was originally conceived, developed, and managed. In order to provide a beginning framework for describing the events that took place with regard to command consultation, an exploratory focus was first used. The approached followed Glaser and Strauss's strategy of "grounded theory": a method that focuses on setting out steps which aim at discovering the concepts and hypotheses associated with a given area of study.[1] Use of the grounded theory approach was based on the idea that this methodology could provide a practical means for deriving and processing information about real world events directly from those individuals who had first hand knowledge and experience.

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[1]Barney G. Glaser and Anselm L. Strauss, The Discovery of Grounded Theory: Strategies for Qualitative Research (Chicago: Aldine Publishing Co., 1973).

Denzin presents this research strategy as "The life history." It ". . . presents the experiences and definitions held by one person, one group, or one organization as this person, group or organization interprets those experiences."[2] Denzin goes on to say that ". . . recording the unfolding history of one person's, one group's, or one organization's experiences . . . becomes a hallmark of the life history, the capturing of events over time. The sociologist employing the method becomes a historian of social life."[3] The basic assumption of this process is that historical events can be ideally explored from the perspective of the individuals who initially experienced them first hand. Gleaning insight and ideas through such an exploratory research was regarded as a pragmatic approach for not only detailing the empirical events that occurred, but also for uncovering the relevant issues of the study.[4] Thus a multi-phased approach was developed to generate a sense of the recurring processes and events of a movement, to collect the relevant recorded historical materials, and to locate and interview informed witnesses to the event. The research method was divided into

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[2]Norman K. Denzin, The Research Act: A Theoretical Introduction to Sociological Methods (Chicago: Aldine Publishing Co., 1970), p. 220.

[3]Ibid., p. 22.

[4]Claire Selltiz, et al., Research Methods in Social Relations (New York: Holt, Rinehart & Winston, 1964).

two phases: (1) A preliminary exploratory phase, and (2) a full scale study phase. This chapter will focus on the procedures followed during these two distinct phases of the inquiry.

Preliminary Exploratory Phase

The first considerations in the research methodology were to conduct a literature search and to inquire into the current status of command consultation practice in the U.S. Army. Exploratory phone calls were made to social workers in six Army Mental Hygiene Consultation Services. Correspondence was initiated with four persons who had been identified in the literature search as having knowledge of or experience with command consultation developments. Personal interviews were conducted with the social work consultant and psychiatry consultant in the Office of the Surgeon General, U.S. Army. Field visits were made to three U.S. Army installations in northeastern United States where command consultation activity was reported to be taking place. Finally, case by case reviews were conducted of historically preserved annual reports of MHCS operations. This study was carried out at The Historical Unit, Ft. Dietrick, Maryland, during the spring months of 1975. Thus, these steps provided the first empirical generalizations regarding the problem of command consultation innovation and established the structural framework for the next step in the research.

The next step in the early conceptualization of the problem consisted of twelve pilot interviews with current and former social workers in the Army. The purpose of this phase of the investigation was to obtain information for further refinement and clarification of the major issues. The method employed continued to follow the "Grounded Theory" approach in which the techniques of "constant comparison" and "the experience survey" were used.[5] On the basis of the information gathered through this process, a specific series of questions would be chosen for a more comprehensive survey of the larger community of Army social workers who were in the best possible position to observe the historical evolution of command consultation. The following paragraphs describe the exploratory interviews and set out the initial observations and findings.

The twelve respondents for the pilot phase of the research were selected on the basis that they had been identified with the Army social work program prior to 1965 and that each individual had some knowledge of the command consultation function. Because of travel limitations on the researcher, the selection of respondents was restricted to twelve individuals residing within a 250-mile radius of a major metropolitan city in the northeastern United States. Each respondent was interviewed one time and the pre-test

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[5]Glaser and Strauss, Grounded Theory, p. 49.

population consisted of the following categories of participants as shown in Table 1.

TABLE 1

PILOT TEST PARTICIPANTS

	Category	N
I	Career Social Work Officers, retired with minimum of 20 years service.	6
II	Career Social Work Officers, active duty with minimum of 14 years service.	2
III	Social Workers with enlisted status, having served limited duty tours from 1942 - 1946.	2
IV	Social Work Officers with limited duty tours from 1956 - 1962	2
	TOTAL	12

There were two important distinctions among the groups. First, the social workers in categories I and II were career oriented and those in categories III and IV served specific tours of duty and returned to civilian practice. Second, only social workers from category II were likely to have knowledge regarding the current status of command consultation. All others had been discharged or were retired from the military and were therefore not likely to know about the current status of command consultation.

The twelve pilot interviews were conducted over a six-week period of time. An initial cluster of four interviews was completed within four days. The insight gained in this first series of interviews was then used to modify a

succeeding cluster of four interviews. Again, the information was analyzed, and the new insights were further modified and integrated into the third and final series of four interviews. This repeated and successive process of modifying the interviews was in accordance with grounded theory procedure and served as a useful technique in keeping the interviews up to date with the increased understanding of the situation. Each interview lasted from two to three hours. All respondents consented to the tape recording of the session. Participation of each subject was completely voluntary and each individual was informed that replies would be anonymous and held in strict confidence.

The interviews covered a wide range of factors thought to be associated with command consultation. The intent of these preliminary interviews was to determine the respondents' own feelings, attitudes, and behavior regarding command consultation. The format of the interviews was designed to permit as free a discussion by the respondents as possible. This approach was maintained for the initial eight interviews with the information acquired, continuously refined, and incorporated into the subsequent interviews. This procedure made it possible to develop properties associated with the growth of command consultation. Clustering interviews in the manner described offered the researcher an opportunity to probe different dimensions of the problem until a saturation point was reached. After completion of the seventh and

eighth interviews, repetition became increasingly apparent, and new themes were no longer generated by the subjects. During the final four interviews, the earlier format of "open-ended" questions was maintained; however, during the second and third hours of these concluding interviews, a more standardized approach was adopted in order to begin the process of formalizing a questionnaire for the next phase of the study.

When the pilot interviewing was completed, a pilot survey questionnaire was developed based on all ideas and information generated by the interviews, literature search, phone calls, and correspondence. Three months after the pilot interviews were completed, the first draft of the survey questionnaire was mailed to each of the same twelve individuals who participated in the pilot discussions. The respondents were asked to elaborate on specified items and to provide added clarification. The letter requesting this follow-up is presented in Appendix A. Eleven of the twelve individuals taking part in the pilot portion responded to this follow-up pre-test of the survey instrument. Their responses were used in further refinement of the final survey instrument.

During the pilot interviews, several respondents stated that social workers were not the only individuals involved in introducing command consultation in the Army. The names of ten former military psychiatrists and three

military psychologists were given by the pilot survey respondents. They suggested that these persons would be valuable resources for tapping additional information pertaining to command consultation's early development. This suggestion to query selected psychiatrists and psychologists was considered sound and especially consistent with Glaser and Strauss's concept of selecting comparison groups for ". . . furthering the development of emerging categories" of information.[6] Soliciting expert opinion from specially selected groups of individuals is a research approach known as the Delphi Technique. This approach was initiated and it had a useful outcome in the effort to "gather current and historical data not accurately known or available."[7]

Contact was established with the psychiatry and psychology consultants in the Surgeon General's Office. Names of fifteen individuals were provided by each consultant and added to the thirteen psychiatrists and psychologists suggested by respondents in the pilot interviews. A supplementary sample of twenty-eight psychologists and psychiatrists was finally obtained. Contact could only be established with nineteen of the twenty-eight individuals, and of this number, thirteen persons agreed to respond to a series of command

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[6] Ibid.

[7] Harold A. Linstone and Murray Turoff, The Delphi Method: Techniques and Applications (Reading, Ma.: Addison Wesley Publishing Co., 1975), p. 4.

consultation issues to be specified in a subsequent mailing. Appendix B presents the letter and statement of issues that were mailed to the thirteen respondents. Twelve responses were eventually received, eight of which were in the form of cassette recordings and four by letter. The data were processed by content analysis and further integrated into the final survey instrument.

To review, the preliminary exploratory phase of this study consisted of a sequence of procedures that were designed to reveal the significant issues of the study and to generate an understanding of what led to the demise of the command consultation movement. These procedures included a literature search, exploratory phone calls, correspondence, cassette tape recordings, personal interviews, and a pilot survey. Based on the information gleaned from these preliminary procedures, the immediate objective of isolating recurrent themes about command consultation was met. However, while those individuals in the pilot procedures may have been experienced and qualified to speak about command consultation, it was still a numerically limited sample. Therefore it was next reasoned that a more complete explanation and verification of the events surrounding the command consultation movement would be needed from the larger community of Army social workers who had actually been the participants. In order to meet this objective, a full scale survey was conceptualized, and a questionnaire was developed

based on the substantive issues that had emerged out of the early interviews and pilot surveys. The full scale survey is presented as Appendix C.

The Major Issues

The steps used in the pilot survey disclosed a broad range of factors relevant to the establishment, management, and practice of command consultation. This section will review the core issues that were identified in the preliminary procedures. In addition, a sample selection of questionnaire items will be presented—items which were originally based on these core issues and ultimately incorporated into the expanded, full scale survey questionnaire. (Again, see Appendix C.) These issues are briefly described in this section; more detailed aspects are presented in a subsequent chapter. The significant recurrent themes that emerged in the preliminary exploratory phase were categorized as follows:

1. Respondent experience and involvement in command consultation
2. Overall historical proliferation of command consultation
3. Nature and characteristics of command consultation
4. Institutionalization of command consultation
5. The status of the social work profession and its resulting impact on command consultation's diffusion

Respondents' Experience and Involvement

Discussions in the pilot interviews focused heavily on how respondents conceived of command consultation, on the extent to which they accepted it, and the degree to which they participated in it. The dominant theme that emerged out of the pilot phase was that universal acceptance of the principle of the command consultation function was professed. While there was criticism of various operational or practice aspects of command consultation, overwhelming consensus existed with regard to the conceptual legitimacy of the practice. This was true with respondents who had actually engaged in command consultation, thought they practiced it, or merely heard about it. While many individuals in the pilot phase stated that they had been in settings where it would not have been feasible to employ command consultation techniques, they asserted that this innovation had theoretical merit and had been highly valued throughout the internal structure of the Army social work program.

In the process of assessing the respondents' overall attitude, the extent of their conceptual understanding, and the levels of their acceptance and participation, great variations were observed. These differences indicated why command consultation practice had such difficulty in sustaining itself and in becoming properly operationalized throughout the mental health program of the Army. A sample

of the kind of questions that emerged from this topic are noted below:[8]

ITEM #6: How did you react to the concept of command consultation when you first learned about it?

ITEM #15: What was the extent of your knowledge of command consultation?

ITEM #16: To what degree did you practice command consultation?

ITEM #18: What degree of satisfaction did you derive from your experiences with command consultation?

Historical Perspective

The command consultation movement was an innovation that evolved over an historical time period from the early 1950s through the early 1970s. Respondents in the pilot phase of the project spoke of varied perceptions of command consultation—perceptions that were related to the particular moment in time that each individual had been identified with the Army social work program. The ideas that surfaced in relation to the sequence of historical events prompted the following questions:

ITEM #24: How do you evaluate the overall development of command consultation during the following time periods?

ITEM #25: To what extent do you think command consultation was generally understood among most Army social workers during each of the following time periods?

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[8]The items presented here and in subsequent portions of this chapter are selected as samples from the larger survey instrument. The complete questions and instrument appear as Appendix C.

ITEM #60: During the following time periods, what emphasis has been given to command consultation topics at conferences or meetings?

Characteristics

A reoccurring issue that emerged in the pilot interviews had to do with desirable and undesirable characteristics associated with command consultation. The experiences with command consultation that were reported by respondents, in nearly every case, centered around several basic characteristics of innovations that have been classified by Rogers.[9] For example, the relative advantage of command consultation was described by individuals interviewed in the pilot phase in terms of efficacy comparisons with traditional forms of clinical activity. The extent of command consultation's compatibility with existing values of social work and the military was a frequently raised subject. The complexity versus simplicity of command consultation was often cited as a factor that accounted for the degree to which practitioners chose to utilize it. This series of items are examples of questions developed from the ideas centering on the characteristics of the command consultation innovation:

ITEM #28: What degree of difficulty do you as a social worker assocate with command consultation?

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[9]Rogers and Shoemaker, Communication of Innovations. For discussion, see Chapter I, pp. 16 & 17.

ITEM #41: The following characteristics have been considered by some Army social workers to interfere with the successful implementation of command consultation programs. Indicate the degree to which you think these items interfere with command consultation activity.

Institutionalization

Throughout the exploratory phase of the study, there was frequent discussion about the degree to which it was believed that command consultation had gained system wide support and acceptance. The initial sampling of twelve social workers and two psychiatrists revealed confusion over the extent to which these respondents believed that command consultation was effectively integrated into the Army's organizational structure. The term used in this study to describe this process is "institutionalization," and it is defined by Broom and Selznick as the efficient integration of an idea or behavior into the established social system.[10] Parsons and Shils establish that ". . . institutionalization must be regarded as the fundamental integrative mechanism of social systems."[11] The importance of this concept to this study is rooted in the belief that an organization must be

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[10]Leonard Broom and Philip Selznick discuss the concept "institutionalization" in relation to societal norms and the associated sanctions that pertain to these norms. See the authors' text entitled Sociology (New York: Harper & Row, 1963), p. 69.

[11]Talcott Parsons, Edward A. Shils, and James Olds, "Values, Motives, and Systems of Action," in Toward a General Theory of Action, eds. Parsons and Shils (New York: Harper & Row, 1962), p. 150.

able to generate capabilities for developing and maintaining a stable framework for innovation. In the case of command consultation, it was found that respondents had diametrically opposite notions regarding the extent to which they believed the consultation movement had gained credibility at the higher echelons of policy formation. It was thus posited that if formal sanctions and supports of the greater organization were indeed absent or poorly established, prospects for success and wider adoption of the consultation function were likely to be substantially compromised from the outset. In order to verify the extent to which command consultation was institutionalized, several elements were identified: (1) the level at which policy was formulated; (2) the presence or absence of policy directives, regulations, and training manuals; (3) the state of the literature; (4) the process of teaching and training; (5) the regularity of professional meetings and conferences; and (6) the means of evaluation and verification.

In order to determine the extent to which institutionalization had in fact taken place, questions such as the following were incorporated into the full scale study questionnaire:[12]

> ITEM #56: To your knowledge, did the Department of the Army ever give official support and sanction to the practice of command consultation?

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[12]The reader is again reminded that the items presented here are selected as samples from the larger survey instrument. The complete questions and instrument appear as Appendix C.

ITEM #57: Are there specific Army regulations which provide an official mandate for the practice of command consultation?

ITEM #59: To what extent have the training manuals explained command consultation practice?

Status of the Profession

A persistent theme throughout the exploratory phase of the study centered around the connection between the command consultation movement and Army social work's status as a profession. It was not surprising that this issue surfaced, particularly since the subject of social work's professional standing in general had been a continuing controversy since Abraham Flexner formally raised the question in 1915.[13] Respondents in the pilot interviews observed that the command consultation movement had special appeal to Army social workers because this new practice function provided a potential means through which they could strive for increased professional recognition and autonomy. The term that will be used in this study to refer to the process by which social work sought to gain this acceptance and recognition is professionalization. Because several respondents directly asserted that the developing practice of command consultation was closely associated with the professionalization of social work in the Army, further substantiation and explanation of this idea was believed necessary. The following sampling of

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[13]Abraham Flexner, "Is Social Work a Profession?" Proceedings of the National Conference of Charities and Correction (Chicago: Conference of Charities and Correction, 1915).

questions was developed to provide a more thorough accounting of the status issue:

ITEM #45: What impact do you think the development of command consultation activity had on the professional status of Army social work?

ITEM #46: Was Army social work administratively/ professionally subordinate to psychiatry during the following time periods?

ITEM #53: In the settings of the mental hygiene programs of the Army, do you think that the relationship between social work and psychiatry was significantly altered when social work achieved separate service status in the latter half of the sixties?

ITEM #55: The achievement of separate service status had the following effect on Army social work involvement in command consultation.

Full Scale Study

The issues and questions drawn from the preliminary pilot phase of the study were synthesized and judged to require further verification from a larger sample of social workers who had been influenced by the command consultation movement. The process of locating those individuals who needed to be included in this investigation required many procedures. In fact, the steps pursued in seeking out the appropriate targets of the consultation program was in its own right a micro-research effort. The endeavor necessitated a thorough and meticulous process of re-assembling a population that had been scattered both historically and geographically. Thus, the focus for selecting a sample population for the survey phase of the study was to determine

which Army social workers would be best qualified on the basis of their actual exposure to evaluate and comment on the developments of command consultation practice.

Screening Procedure

The primary factors for selectively screening a sample participant had to do with his experience, knowledge, and practice. One category of Army social worker which could automatically be included in the study was the 20-year careerist who had achieved retired status, because any individual within this category who spent this length of time in the program would logically have been present during the time when the command consultation movement was alive. Furthermore, any individual in this category was believed to have had the opportunity to have been exposed to command consultation.

The rationale employed in selecting the 20-year careerist was also used in choosing a second category of Army social worker, i.e., the individual on active duty with a minimum of ten years of active service. While it was understood that the range of understanding, knowledge, and practice varied among these social workers, the period and length of time with which they had been associated with the Army's social work program was considered to be an adequate justification for automatically including them as members of the sample population. In other words, by the sheer amount of time spent, these individuals had to be aware of the event.

This was one of the early assumptions in the screening process, and one that was empirically validated by the initial pilot interviews.

Selection Procedure

The first list of retired Army social workers was obtained from the social work consultant in the Surgeon General's Office. Three other social workers who were contacted by phone added additional names to this list. The social work consultant and the three social workers were asked if they believed that the mere presence of those social workers on the list whom they identified was adequate justification for including them in the survey. They all stated that it was an acceptable criterion concurring that the only way these individuals could not have been aware of the events of the time was, as one social worker said, "if they had had their heads in the sand!" Another said that command consultation was such a ". . . substantive part of the Army social work program, that any career oriented individual would certainly have had familiarity with and knowledge of it."

This initial step in the selection of a sample population yielded approximately seventy names of active and retired social workers, all of whom had considerable overall experience and association with the Army social work program. From this list, nine individuals had already been chosen for pilot interviews as discussed earlier. Each of these nine individuals were recontacted by phone and asked to identify

social workers whom they believed were involved in the overall development and practice of command consultation. Each respondent gave the names of approximately twenty to thirty social workers whom they recalled. Any names mentioned which were not on the original list were then added to it. At the completion of the pilot surveys, the sample list had been expanded to ninety names. Thirteen individuals on this list of ninety names were not long term career officers. The range of experience for these persons had been from three to five years. The respondents in the pilot survey noted that even though these persons were in the Army social work program for a relatively brief periof of time, they had nevertheless practiced command consultation as extensively as any career person. They also noted that they felt the knowledge of these persons regarding command consultation was quite extensive.

This information led the investigator to conduct telephone inquiries with three of the thirteen non-career social workers. These discussions confirmed the respondents' views that these individuals did have substantive knowledge of command consultation events. Further, these three social workers were asked if they could identify the names of other associates whom they thought were relatively well informed on command consultation. Eleven additional names were given and subsequent calls to these persons revealed that four were indeed highly familiar with command consultation activity,

three had more limited knowledge, and the remaining four had practically no awareness of what constituted command consultation.

This progressive process ultimately yielded over three hundred names and at the same time, led the researcher to several conclusions: (1) that there were many social workers, past and present, who had a wide range of experience with and knowledge of command consultation; (2) that the original notion that the sample population would be strictly limited to the most experienced Army social workers could not be maintained; and (3) that a more open method was needed to determine what additional persons were also familiar with command consultation events so that, as knowledgeable informants, they could be included in the study.

A two-stage sampling procedure was next initiated to (a) identify "non-career oriented" Army social workers and (b) assess their knowledge of and/or experience with command consultation.

Identification Procedure

A one-page screening survey was developed and mailed to 334 individuals presently practicing social work in the civilian community (see Appendix D). The sample was chosen from four dated rosters that contained the names of social workers who had served on active duty since 1958. The first mailing or selection drew upon a 1969 roster of 239 social work officers serving in the U.S. Army reserve components.

The second mailing went to 46 individuals whose names had been on a 1968 active Army roster of social work officers. The third mailing was sent to 30 individuals whose names were listed on a 1971 active Army roster of social work officers. The fourth and final mailing consisted of 24 individuals whose names had been obtained from attendance records of social work and inter-disciplinary professional conferences in the late 1950s and early 1960s.

One of the significant problems that developed in the identification procedures was locating individuals who had been absent from the Army social work program for as many as ten to fifteen years. The most practical method of tracing the addresses of many respondents was through the 1972 Directory of Professional Social Workers.[14] Those individuals who did not maintain an address listing in the directory were not included in this phase of the study because there was no practical method to trace them.

Assessment Procedure

A brief explanatory note was written at the top of each screening survey page (also presented in Appendix D). The letter explained the purpose of the project and identified that the individual's name was obtained from a dated roster of U.S. Army Reserve or Active Army Officers. Each

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[14]National Association of Social Workers, 1972 Directory of Professional Social Workers (New York: National Assn. of Social Workers, 1972).

individual's assistance was requested by asking for information about their knowledge of command consultation. Finally, those respondents who indicated that they were knowledgeable or had experience were also asked to define or identify in their own words their understanding of what constitutes command consultation. Content analysis was used to judge the responses. Assesment was based on definition and principle criteria that had been established during the twelve pilot interviews with current and former social workers in the Army. If the responses were congruent with the criteria established, these individuals were included in the expanded version of the survey. Table 2 summarizes the distribution and response categories of the preliminary mailing.

TABLE 2

SUB-SAMPLE DERIVED FROM SCREENING SURVEY "PROBABLE" INFORMANTS

	1st Mailing	2nd Mailing	3rd Mailing	4th Mailing	Totals
Total Mailing (N)	234	46	30	24	334
Response Rate	124	22	13	14	173
Surveys Returned by Postal Service Undeliverable	31	10	7	3	51
No Response	79	14	10	7	110
Respondents Selected to Receive Larger Survey	46	20	11	10	87

It is noted, particularly that of the 334 individuals screened, 87 respondents were selected to be included in the final survey. This total was combined with the list of 127 selected active duty social workers not requiring screening, thus producing a final mailing roster for the full scale study that consisted of 224 names of former and current Army social workers.

Analysis of the Full Scale Survey

Data for studying the command consultation movement were collected from numerous sources as already mentioned in this chapter. To review, the data were gathered from pilot interviews, conference proceedings, literature, letters, phone calls, cassette tape recordings, and archival collections. The bulk of the data, however, was generated by the full scale survey. The process by which this full scale survey evolved has also been described, and this portion of the discourse will explain the procedures that were used to convert the raw data into a manageable format for analysis.

The design of the full scale survey was based on the accumulated knowledge that was generated by all of the previous investigation mentioned above. The information gleaned from the pilot research was consistent with grounded theory procedure and established the context for the questionnaire items. Thus, the full scale survey was to serve as a vehicle through which the greater community of Army social work

informants could enrich and verify the expanding theory regarding command consultation's life cycle. The survey questions were therefore related to the emerging theory of the research and the objective of these questions was to encourage study participants to provide a full accounting of their knowledge and experience.

The data were collected in the full scale survey within the context of two formats: (1) The majority of the items had fixed response categories which provided for a pre-coded, readily scoreable procedure. (2) Seven items in the full scale survey were of an open-ended nature designed to capture respondents' unique, individualized experiences. It is noted that respondents were specifically invited to comment freely on any questionnaire item by using the backs of the pages. Coding of the dispersed comments and responses to the seven open-ended questions presented a more complex task than the fixed response items. For one thing, considerable variability existed from respondent to respondent. It was found that reducing this data for coding purposes tended to dilute the richness of the information. Therefore, it was decided that the unique content of the comments and responses should not be sacrificed for the convenience of mechanical analysis, but rather, this data would be retained in its pure form and captured verbatim in the relevant discussion portions of the study. In certain instances, specific comments and responses were categorized and subjected to an analysis

of content. Emerging themes and generalizations were thus developed and when applicable presented as such in the study findings.

A data processing procedure was subsequently initiated in which the fixed response data from the 163 respondents were coded and converted onto standard computer punch cards. Key punching was verified and checks for accuracy were completed by comparing the final print-outs with the code sheets. This was randomly done with every third card and no errors were discovered.

The computer program chosen for analysis of the data was Statistical Package for the Social Sciences (SPSS). SPSS was specifically selected because of its unique design features for processing social science data. It allowed for a wide range of flexibility in managing the data and afforded the researcher the use of "natural language control statements."[15] This analysis system did not require previous computer experience, so that the researcher was able to maintain control of and personally manage his own data. Descriptive statistics, simple frequency distributions, cross-tabulations, and factor analysis were used to evaluate the research material.

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[15]Norman Nie, Dale H. Bent, and C. Hadlau Hull, Statistical Package for the Social Sciences (New York: McGraw Hill, 1970), p. 1.

The Final Study Sample

Table 3 presents the response frequencies for the full scale survey.

TABLE 3

RESPONSE INFORMATION TO SURVEY QUESTIONNAIRE

Disposition	Frequency	Frequency Percentage
Questionnaires Returned and Completed	163	72%
Questionnaires Returned by Post Office marked "not delivered"	15	7
Questionnaires Returned by Respondent, but not filled out, incomplete, ambiguous	8	4
No Response	38	17
TOTAL	224	100%

The overall sample selection process ultimately yielded 163 completed and useable surveys for the full scale evaluation. The high response rate (72%) was thought to be attributed to two factors:[16] First, there was a series of two follow-up mailings in which respondents were requested to complete and return their survey. Second, there was a sense of nostalgia among many respondents and this was reflected by

[16]The actual response rate percentage was 78% if adjusted to account for those questionnaires returned by the Post Office marked not delivered.

the comments, notes, and letters attached to the completed surveys. The opportunity for reminiscing over a previous life experience was believed to be a high motivator in producing the response rate that was received.

Summary

It is emphasized that the screening, selection, and sampling effort described in this chapter was not merely a task aimed at locating a "representative" group of Army social work officers from whom a consenses would be obtained over what they believed command consultation was about. The objective was to screen over 500 possible respondents in order to locate only those individuals who were historically the targets of the command consultation movement and those who possessed the most complete knowledge and experience regarding command consultation. Such individuals could serve as informed witnesses qualified to make knowledgeable judgments about what actually took place. Thus, the experience survey sampling plan ultimately yielded 224 potential witnesses and 163 completed questionnaires which was a final study sample representative of suited and qualified social workers who could speak authoritatively on the subject of command consultation's management and proliferation.

CHAPTER III

CHARACTERISTICS OF THE STUDY SAMPLE

The purpose of this chapter will be to theoretically classify and to practically describe the demographic and professional characteristics of the social workers who participated in the full scale study. Such information is intended to provide a more detailed understanding of the principal figures in social work who were associated with the command consultation movement. The first part of this chapter will contain a theoretical classification of the study sample. This will give the reader a framework for examining the overall nature of respondents' involvement in the innovation of command consultation. The second section of this chapter will enable the reader to focus on the respondents' range of practical experience, their levels of knowledge, and the extent to which they participated in command consultation. Specific areas to be described will include (a) demographic characteristics such as age and sex, (b) social work education, (c) civilian professional experience, and (d) military professional experience.

Theoretical Classification

The innovation of command consultation has been an evolutionary process spanning more than thirty years. During this period, the principles who were a part of this innovation process assumed different roles. The 163 respondents in this study were each asked about the kind of role or roles they experienced in relation to command consultation's growth. The respondents were given the opportunity to select, from a series of statements, the experience or experiences that most closely approximated their involvement (or lack thereof) with command consultation.[1] The respondents' own characterization of their roles provided a means for developing a theoretical classification scheme to better understand the nature of their overall involvement in the command consultation movement. The subsequent portion of this chapter will describe this taxonomy.

Innovators

Those individuals who identified themselves as having assumed planning roles and having instituted new and creative command consultation programs with the Army's Mental Hygiene Service were identified as Innovators. Initiall[illegible] pilot interviews reflected characteristics of innovators which were theoretically different from other

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[1]Because respondents were allowed to choose one or more roles, the sum responses presented in this section are more than the total number of 163 respondents in the study sample.

social workers who were not regarded as innovators. The most apparent characteristic which was thought to differentiate innovators was their versatility and capacity for taking on new tasks and untested functions. They spoke of a venturesome quality and a spontaneous readiness for action in sampling original ideas. They were usually the individuals who contributed most heavily to the professional literature and who carried out the leadership functions at conferences and short courses. Interest in authority and concern with professional status also seemed to be a prominent, readily observable trait among these individuals. Thus, two categories of innovators were developed: Planners and policy makers were called conceptual innovators, and initiators of new programs were named functional innovators.

Conceptual Innovators

Thirty-one (31) respondents indicated that they were earlier planners and promulgators of command consultation theory. This segment of the sample of Army social workers subjected the command consultation practice function to clarification and analysis of ideas associated with it. Generally, these conceptual innovators were involved in systematically ascertaining the major characteristics of a helping role relative to a larger system within a complex organization. The conceptual innovators spoke of substantive contributions to the literature and assumed primary

leadership roles in crystalizing command consultation into well integrated practice techniques.

Functional Innovators

Sixty-nine (69) members of the study sample stated that they were "organizers" of command consultation programs. These individuals introduced command consultation into practice settings and developed the activity operationally. These social workers were the principal change agents responsible for moving existing mental hygiene services away from traditional modes of service, such as clinical activity, into the direction of indirect, consultative activities. They translated their awareness and knowledge of command consultation into viable, empirical programs.

Practitioners

The second classification of social workers who played a role in the development of command consultation were the practitioners/participants. These persons were in practice settings where command consultation had been initiated or operationalized prior to their own arrival. The practitioners were those individuals who had practical opportunities to engage in this innovative activity. They were the social workers with line duties who carried out their professional functions primarily within the guidelines of the established programs. Where the innovators conceived of new and changing functions for program development, practitioners generally

engaged in the actual process of carrying out these tasks. Three categories of practitioner roles were identified: (1) Early Adopters, (2) Late Adopters, and (3) Rejectors.

The Early Adopters

The social work practitioners who most readily and enthusiastically accepted the principles of command consultation were regarded as the early adopters. Seventy-four (74) respondents stated that they participated in command consultation before most of their colleagues. This group of social workers was considered to be highly receptive to learning about and testing out their consultation skills and techniques.

Late Adopters

Forty-eight (48) members of the study sample noted that they participated in command consultation after seeing from the experience of colleagues that it was a useful function. While early adopters eagerly accepted command consultation, the late adopters were considered to be more hesitant, thoughtful, or resistant in taking on this practice function. Some late adopters were initially skeptical of the idea, and others felt ill-prepared to do it. Careful deliberation and caution tended to guide the manner in which this group of social workers engaged in consultation activity. Yet, all social workers in the late adopter category would eventually come to accept command consultation.

Rejectors

The early adopters were eager to practice command consultation, late adopters were more hesitant, but the rejectors declined to engage in the activity. Two respondents said that while they were exposed to command consultation, they chose not to participate. While members of this group usually tried to do it, they usually encountered dramatically unpleasant experiences which soured their view of command consultation. A respondent in the pilot interview stated that while interfacing with commanders in the field had value, he did not feel that he was personally suited for the role. He recalled observing another social worker conduct a consultation with a commander and stated that he remembered being troubled by the "complexity" of the overall task which confronted his colleague. He specifically recalled the adamant resistance of the consultee and his own feelings of discomfort as an observer through the entire process. When asked how he could have been more personally suited to the role, the respondent acknowledged that he did not have the "assertive instincts and professional style necessary to seek out commanders." Still others felt that the value of command consultation had shortcomings and decided that the provision of direct services to clients was more compatible with their professional training and philosophy.

Observers

Not all social workers in the Army social work program were involved in the innovation or participation of command consultation. Nine respondents reported that because of the nature of their assignments, they never had actual opportunities for consulting with commanders. Respondents who played no role as innovators or practitioners were asked to elaborate on the fact that they were never exposed to the direct practice of command consultation. None of the individuals in the study sample indicated that the following item pertained to them: "Since my assignments never offered exposure to the direct practice of command consultation, I never heard anything about it and am therefore totally unfamiliar with the activity." All nine respondents stated that they knew about the command consultation activity from observations, colleagues, conferences, papers, the literature, etc. In chapter two, it was stated that the research method was designed to select only those individuals who could serve as expert witnesses to the innovation of command consultation. However, lack of participation or practice of command consultation was not, alone, a factor for exclusion of an individual from the study sample. Knowledgeable observers of an innovation process may play an important role in relating the history of what took place. The careful screening procedures described in chapter two yielded nine respondents who were sufficiently informed about the events relating to command

consultation. These respondents were classified as observers possessing awareness, knowledge, and feeling for how command consultation evolved.

In summary, the study sample members were classified as innovators, practitioners, and observers. Each of these classifications was further divided as follows: conceptual innovators, functional innovators, early adopters, later adopters, rejectors, and observers. The purpose of developing this theoretical scheme has been to document the substantial diversity of respondent experiences and roles. This taxonomy establishes a visual framework for perceiving the involvement of these respondents in the command consultation program. It is particularly emphasized here that because of the purely investigative and exploratory nature of this study, delineation of these categories should be construed purely as a "descriptive" (rather than a "grouping") variable among the respondents. Correlating these typologies with specific causal outcomes was clearly not the intent or purpose of this study. Such an attempt would require role validation and collection of additional data such as local implementation measures of command consultation, outcome data derived from specific practice locations, etc. Clearly, such an effort falls outside the scope of this study which centers on exploring the general historical development of an innovation. This defines a needed follow-on study on which future research could be based.

Sample Characteristics

The 163 respondents in this study were all social workers who had served in the Army social work program during the last thirty years.

Age and Sex

The age distribution for the overall study population is described in table 4.

TABLE 4

DISTRIBUTION OF RESPONDENTS BY AGE

Age Range	Frequency	Percentage
29 or less	6	4%
30 to 35	64	39
36 to 40	21	13
41 to 50	45	28
51 to 60	22	13
Over 60	4	2
Unknown	1	1
TOTAL	163	100%

The largest percentage, nearly forty percent of the respondents, were in the age bracket 30 to 35 years and eight percent of the total sample were between 30 and 50 years of age. Newly commissioned officers in the military are normally in the twenties age bracket. Since just six members of the sample were age 29 or less, this indicated that the

screening procedures had produced a selection of social workers who had several years experience in the social work program with corresponding probable exposure to command consultation.

Table 5 displays the actual length of time in which the respondents were associated with the Army social work program.

TABLE 5

DISTRIBUTION OF RESPONDENTS BY TIME ASSOCIATED WITH THE ARMY SOCIAL WORK PROGRAM

Time	Frequency	Percentage
Zero to two years	9	5%
Three to five years	64	39
Six to ten years	23	14
Eleven to fifteen years	22	14
Sixteen to twenty years	31	19
Over twenty-one years	14	9
TOTAL	163	100%

Table 5 clearly shows that the respondents participating in this study were not simply one- or two-year people who had entered the service and departed. While the heaviest emphasis happens to be in the three- to five-year period, the remaining categories are well represented with 42 percent of the respondents affiliated with the Army social work program from eleven to possibly thirty years.

Of the total sample, 162 individuals were male and one was female. This .6 percentage of females in the study sample is lower than the 7 percentage of females generally found in the Army social work program. Within the framework of civilian social work practice, the ratio of males to females is reversed, and while it is not a part of this study to describe this in detail, it is important to recognize that the sample population of Army social workers in this study with respect to sex is not representative of the civilian social work community at large.

Social Work Education

The level of education for the study population is presented in table 6.

TABLE 6

DISTRIBUTION OF RESPONDENTS
BY HIGHEST ATTAINED LEVEL
OF SOCIAL WORK EDUCATION

SW Education Level	Frequency	Percentage
Master's Degree	62	38%
Post Master's Degree	47	29
Doctoral Degree	54	33
TOTAL	163	100%

The master's degree in social work is the primary requirement needed by an individual in order to be accepted into the Army

social work program. Over 60 percent of the sample population in this study indicated that their professional social work education surpassed the master's level. Exactly one-third of the sample possessed doctoral degrees. The implication for this study is that the sample was comprised of individuals with a broad academic knowledge base and a corresponding likelihood of greater research expertise than the average social work practitioner. It is emphasized that in the general Army social work population, far fewer than one-third of these individuals have doctoral degrees. The special screening procedures used in this study were to select only those individuals most qualified to speak as witnesses to the evolution of the command consultation movement. It is of interest that those individuals who were qualified to speak to this event also happen to be individuals possessing high levels of social work graduate education.

Table 7 describes the emphasis of the sample's study sequence in the respondents' social work graduate school education. The predominant emphasis in graduate work study has traditionally been casework, and this was reflected by nearly 60 percent of the sample. Twenty-five percent described a generalist experience in graduate school. Eight members of the sample had an emphasis in the community organization sequence, and this is of particular significance since command consultation is normally considered to be related to a professional ideology directed at practice

TABLE 7

DISTRIBUTION OF RESPONDENTS
BY STUDY SEQUENCE

Social Work Study Sequence	Frequency	Percentage
Casework	96	59%
Group Work	12	7
Community Organization	8	5
Generic	40	25
Other	7	4
TOTAL	163	100%

models emphasizing prevention, systems, and community organization. Thus, it is often suggested that the greater the emphasis in one's professional training toward prevention or a systems approach, the more likely it would be for that individual to engage in command consultation practice functions. That only 5 percent of the sample population indicated a community organization graduate school orientation is noteworthy.

Respondents were asked whether they had acquired academic familiarity with the general principles of consultation. Forty percent answered affirmatively and 60 percent gave a negative response. The analysis portion of this study will review the extent to which respondents' educational background prepared them for involvement in the establishment of the command consultation movement.

Military Versus Civilian Status

At the outset of the study, it was recognized that both current and past affiliated members of the Army social work program were the individuals best qualified to account for the events pertaining to command consultation's evolution. Table 8 shows this distribution.

TABLE 8

DISTRIBUTION OF RESPONDENTS BY MILITARY AND CIVILIAN STATUS

Status	Frequency	Percentage
On current active duty Social Work program	53	32%
Retired from military with 20 or more years of service	34	21
Civilian without military retired status	62	38
Reservists	14	9
TOTAL	163	100%

In this study, 68 percent of the respondents were former military social workers who returned to the civilian community. Of these, 34 individuals had 20 or more years of military service. A total of 53 respondents were on active service in the Army social work program.

Table 9 presents the highest level of rank attained by the respondents while they served in the Army social work program.

TABLE 9

DISTRIBUTION OF RESPONDENTS
BY MILITARY RANK

Rank Category	Frequency	Percentage
Lieutenant	3	2%
Captain	79	49
Major	25	15
Lieutenant Colonel	44	27
Colonel	11	7
TOTAL	162*	100%

*One response missing.

Almost one-half of the sample were captains. Twenty-five respondents were majors and forty-four individuals had reached the rank of Lt. Colonel. Eleven respondents were colonels. Normally, the acquisition of higher levels of rank is a function of time spent in military service. The company grade ranks of Lieutenant and Captain constitute about fifty percent of the sample, and the field grade ranks of Major, Lt. Colonel, and Colonel comprise the remaining fifty percent of the sample. This distribution is notable since it reflects a balance among the respondents with regard to overall time and experience spent in the Army social work program.

Of the respondents in the sample, forty percent had non-social work military service in addition to their experience as Army social work officers. The sixty-five individuals comprising this portion of the sample had served in both enlisted and commissioned ranks. The scope of their service

ranged from Naval, Marine Corps, and Air Force duty to active involvement in the combat service support components of the Army. Eighteen percent of the sample had served during World War II or in the Korean Conflict. This cross section of experience is mentioned as an important factor which shows that the sample had a broad familiarity base with aspects of the military beyond the mental health and behavioral science framework of the social work discipline.

Civilian Social Work Experience and Consultation Practice

The degree of consultation experience that individuals brought to the Army social work program from civilian practice is shown in Table 10.

TABLE 10

DISTRIBUTION OF RESPONDENTS BY EXTENT OF CONSULTATION PRACTICE IN CIVILIAN SETTING PRIOR TO ENTERING THE ARMY SOCIAL WORK PROGRAM

Category	Frequency	Percentage
Practiced consultation in civilian setting	59	36%
Did not practice consultation in civilian setting	104	64
TOTAL	163	100%

Upon completion of graduate social work education and prior to entering the Army social work program, two-thirds of the respondents indicated that they did not experience or practice consultation in the civilian social work setting. The implication is that if the Army expected to carry out a successful consultation program, it could not rely on prior academic familiarity of consultation techniques among its newcomers. The burden, therefore, may have been on the Army to teach social workers entering the Army the concepts and approaches of command consultation. The extent to which this was actually done will be analyzed in the next chapter.

At the time this survey was administered, 110 respondents had completed their military service and had returned to civilian practice. Of these individuals, ninety-three percent stated that they engaged in some form of consultation practice and just seven percent replied negatively. These same individuals were asked if they found the general principles and practices of consultation in the civilian setting to be different from or similar to consultation in the military. Of the respondents who returned to civilian practice and who identified that they had practiced consultation, sixty-six percent stated that the overall principles were similar; thirty-four percent stated that the principles and practices were not similar. The significance of this information is that the study sample was comprised of respondents with varying perspectives on consultation—perspectives that

were influenced before, during, and after their military experiences.

To review, the sample can be characterized as a knowledgeable and highly educated group of social workers representing the active Army social work community and the civilian social work sector. With the exception of one woman, the respondents were otherwise male and their ages span five decades. Sample members had had varying experiences with consultation academically and practically.

CHAPTER IV

FINDINGS AND ANALYSIS

Introduction

The objective of this research is to trace the process through which an innovation called command consultation was introduced, developed, and managed in the U.S. Army. The name itself states that it serves as a consultative service to command rather than a treatment service to the troubled soldier. As such, command consultation has been ideally defined as a program of primary prevention directed toward an overall systems approach for the betterment of the organization. From the time of command consultation's inception, the idea was very popular among most behavioral science practitioners. Yet, despite the broadly professed claims that it was a sound methodology for assisting commanders with human relations problems, the consistent and systematic establishment of this practice modality never fully materialized. Explaining what disrupted this process is the focus of the present study. Identification and analysis of the forces which moderated against the successful adoption and diffusion of command consultation is the subject of this chapter. The study findings are presented and analyzed in five sections of

this chapter. Each section is developed around the following core questions:

(1) What was the overall experience of the social work respondents in relation to their involvement with command consultation?

(2) How did the general historical development of command consultation influence its diffusion throughout the military?

(3) What were the nature and characteristics of command consultation and what impact did these have on the proliferation of the innovation?

(4) To what extent was command consultation institutionalized throughout the Army's mental hygiene consultation service?

(5) What impact did social work's status as a profession have on the adoption of command consultation technology?

Experience of Respondents with Command Consultation

The actual experience that social work practitioners had with command consultation provides a starting point for focusing on what went wrong with the attempt to successfully institutionalize the command consultation process. The experience of the respondents was revealed in the data of the full scale survey, and this portion of the discussion will identify the relevant aspects of the study sample's involvement with command consultation.

Learning About Command Consultation

Interview respondents were asked what year they first learned about command consultation. The major concern that prompted this question was the long range, historical span during which Army social workers were learning about command consultation. If the thrust of the learning experience had been confined to a specific time period, it would be understandable that the movement would have failed to become widely known. The data, however, showed that the respondents had been learning about command consultation from the late 1940s into the 1970s. Throughout this span of over twenty-five years, new people were continually entering the Army social work program and learning about command consultation. The program, thus, was continuously nourished and replenished with people for over three decades.

The length of time in which it has taken individuals to learn about command consultation after entering the Army social work program is of particular interest. The time differential in this learning process was found to be surprisingly short. One hundred three respondents (63 percent) noted that after entry into the Army social work program, they learned about command consultation before one year had elapsed. One hundred forty respondents (86 percent) of the sample stated that they had learned of command consultation within two years of having entered in the Army social work program. It was anticipated that with practically no formal

means established for teaching newcomers about command consultation, the time span would have been much greater. If the time differential for learning about command consultation had been longer, this would have been a plausible contributing factor in command consultation's failure to establish its roots. But, with this inordinately high percentage of respondents learning about command consultation within the first two years, this diminishes one explanation for command consultation's failure to gain ultimate, system-wide acceptance.

The practice of command consultation was widely dispersed in terms of geographic locations and extremely diverse in relation to the professional settings in which it was practiced. Respondents reported experiences in virtually every Army installation abroad and within the continental United States. The settings included the Mental Hygiene Consultation Services, correctional facilities, hospitals, Divisions, schools, staff offices, and Army Community Service centers. Respondents indicated that the setting in which they most often engaged in command consultation was the Mental Hygiene Consultation Service (MHCS). Hospitals, correctional facilities, and the Division followed respectively in terms of the practice settings where command consultation was most likely to have been conducted.

In developing a complete understanding of the full range of involvement respondents had with command consultation,

participants were asked to list chronologically their experiences. Many of the 163 respondents identified multiple experiences, and a total of 502 experiences were reported. The roles that were assumed by respondents with regard to their functioning in command consultation were consultant/worker, supervisor, teacher, and chief. The consultant/worker role was assumed most frequently by respondents during the initial experiences in performing command consultation. Later experiences were characterized by diminishing levels of involvement in actual practice roles (as would be expected), and were replaced by supervisory and chief of program roles. Significantly, the teaching roles were extremely limited. Out of the 502 overall experiences reported above, just 3 percent of these were identified within the scope of the teaching role. This finding reflects an extremely limited effort directed at teaching other MHCS practitioners how to function in the role of consultant and must be considered as significant in the movement's overall development. This issue will be more thoroughly developed and explained at a later point in this chapter.

A measure of whether or not an innovation gains acceptance and is successfully introduced into a social system has to do with the willingness or readiness of its members to participate. Through participation, individual members or practitioners become identified with others in the system who favor and support a new idea. When individuals know that

there is larger commitment and group participation, it is reasonable to assume that there is a greater likelihood that the practice will spread. Therefore, respondents were asked to reflect upon each of the experiences that they had been asked to chronologically list, and then to consider to what degree they practiced command consultation during each experience. Table 11 presents the degree to which respondents indicated that they practiced command consultation during their military experiences.

TABLE 11

DEGREE TO WHICH RESPONDENTS PRACTICED COMMAND CONSULTATION DURING THEIR MILITARY EXPERIENCES

	(N)	Practiced Exclusively	Practiced Frequently	Practiced Occasionally	Practiced Rarely
1st Experience	156	10%	39%	36%	15%
2nd Experience	133	10	47	35	8
3rd Experience	95	8	52	28	12
4th Experience	59	14	47	25	14
5th Experience	31	13	52	16	19

The data in Table 11 show that the most frequently occurring responses are in the category labeled "practiced frequently." The second most popular reply was in the

category "practiced occasionally." Relatively small percentages of the sample said that they practiced it exclusively and few respondents noted that they practiced it rarely. There was a tendency for respondents to increase the degree to which they practiced command consultation in subsequent experiences that occurred through one's career progression. It could be concluded from this information that there was a substantial degree of command consultation activity reported to be taking place among social work practitioners in the military. What is interesting, however, is that this data reflects what participants were saying about their own participation. In terms of what they were describing about the extent to which they perceived other practitioners participating in command consultation, there is a different portrayal of events as expressed in a number of interesting comments:

> ..."I can verify this when it comes to actual practice. I travel all the time looking at programs in the MHCS, and we are just not doing command consultation."
>
> ..."There was a lot verbalized about command consultation but little practice in reality."
>
> ..."You'll find that most of our colleagues pay lip service to command consultation. But, if you're looking for people who are really doing it, don't hold your breath while searching."

Thus, there is an evident and sharp contrast of the respondents' perceptions of their own practice of command consultation and their view of how others engaged in this practice function.

Respondents were next asked to reflect on what level of success they achieved regarding each overall command consultation experience. An average of all experiences showed that 35 percent of the respondents felt they were "highly successful" regarding their command consultation efforts. Only 11 percent thought they were "somewhat unsuccessful" and just 6 percent indicated they were highly unsuccessful in their work with command consultation.

Given the high levels of success as indicated by the previous data, it was not surprising to find similar results with regard to levels of respondent satisfaction derived from each of the command consultation experiences. Of the respondents, 85 percent reported satisfaction and just 15 percent indicated that they were dissatisfied with their command consultation efforts.

The manner by which potential adopters become familiar with an innovation is usually not intuitive or instantaneous. Rather, familiarity with an innovation is a process that develops over time and in a series of sequential stages. The first of these stages has to do with becoming aware of the innovation and gaining some knowledge or understanding of how it operates.

During the preliminary survey, respondents said that there were a variety of ways in which practitioners learned about command consultation. Pursuing this in the full scale survey, respondents were asked the following open-ended

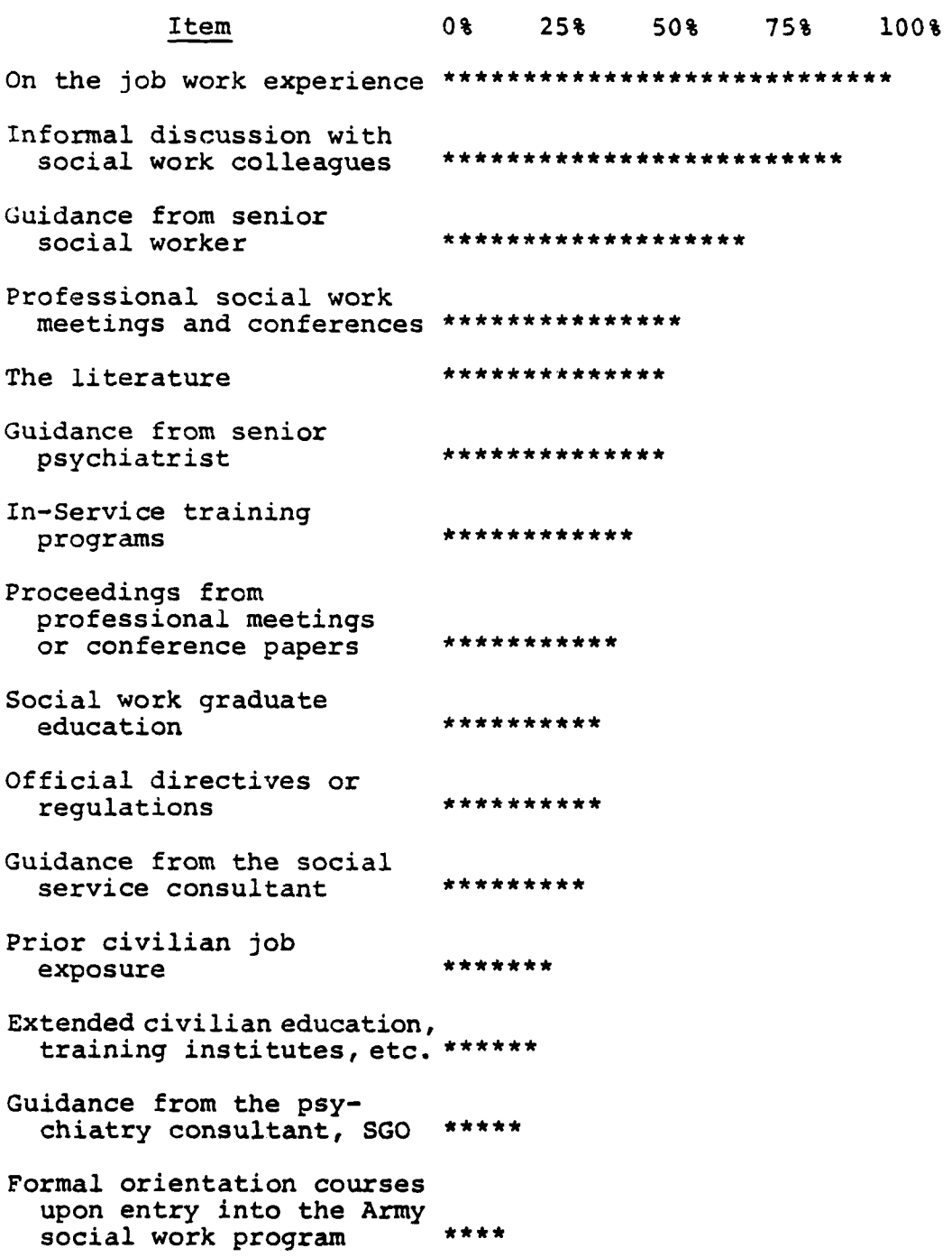
question, i.e., open-ended in that no specific response categories were suggested: "Describe how you first learned about command consultation." The major theme emerging from the replies to this question pointed to the fact that respondents primarily learned about command consultation empirically, i.e., through experience. Peer influence and the literature were also heavily emphasized. Later in the survey, respondents were again asked about their learning experience with command consultation. In this case, a series of pre-selected response categories were set forth. The specific question was posed as follows: "What impact did the following items have in determining the extent to which you learned about command consultation?" The responses to this question are consistent with the open-ended replies. Figure 1 on the following page shows the results of this data.

The data in figure 1 shows that 95 percent of the respondents learned about command consultation as a result of actual on the job work exposure. Informal discussion with social work peers was identified by 86 percent of the respondents as the second most pronounced means by which they learned about command consultation. Guidance from the senior social worker was indicated by 64 percent as the third most important manner in which they learned about command consultation.

In sharp contrast, the data show that the least important mechanism for learning about command consultation as

FIGURE 1

WAYS IN WHICH RESPONDENTS LEARNED
ABOUT COMMAND CONSULTATION



perceived by the respondents was through formal orientation courses at the beginning of a social worker's entry in the Army social work program. Just 12 percent of the respondents felt that the formal mode of learning about command consultation had an impact. The consensus among the respondents was that initial learning experiences with command consultation were largely informal, sporadic, spontaneous, and empirical in nature. Based on the data, a relatively small portion of the study participants believed that the initial learning experiences were in any way organizationally planned or systematically presented to practitioners.[1]

Preparation

It was thought that the nature of the learning experience with regard to command consultation was informal and lacked systematic, institutionalized procedures. The data showed that this assumption was well founded. It was further believed that as a result of not being provided with formal, systematic learning experiences vis-a-vis command consultation, respondents would have been relatively unprepared to engage in command consultation. Respondents were asked about

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[1]During the course of this investigation, the researcher received a letter from a 1st lieutenant who was seeking information about how to initiate a command consultation program at his Army post. Because formal materials were not readily available, this social work practitioner had to use word of mouth procedures and personal letters in order to accumulate necessary information for initiating a command consultation program. A reproduction of this letter is presented in Appendix E.

the degree to which they felt prepared for their role the first time they were called upon to perform command consultation. Table 12 displays the results of this question. It is observed that just 14 percent felt they were "well prepared" for their role; 54 percent replied that they felt "somewhat prepared" and 20 percent believed themselves to be "somewhat unprepared." Twelve percent noted that they felt "highly unprepared." This finding indicates that informal learning (the topic discussed in the previous section) may have been a somewhat adequate means for spreading command consultation with a modest level of understanding and preparedness among the majority of social work practitioners. However, informal learning procedures may not have been sufficient to institutionalize the program and give it long range continuity.

TABLE 12

DEGREE TO WHICH RESPONDENTS FELT PREPARED FOR THEIR ROLE FOR ENGAGING IN COMMAND CONSULTATION

Response Category	Frequency	Percentage
Well Prepared	22	14%
Somewhat Prepared	86	54
Somewhat Unprepared	33	20
Highly Unprepared	19	12
No Response	2	*
TOTAL	163	100%

*Percentages are adjusted to account for ambiguous/missing responses.

Respondents were asked to consider in retrospect how they could have been better prepared for their command consultation role. This question elicited numerous comments in the full scale survey. A steady theme that emerged was that virtually no formal preparation of any kind was given to Army social workers at the time when they entered the Army social work program. This issue was elaborated upon in figure 1, and the following comments provide further detail about this event:

> I could have spent some time at Medical Field Service School learning about command consultation rather than how to do any number of military tasks like organizing a truck convoy. My feeling is that MFSS was largely a waste of time for professional personnel and that they should have been assisted in learning how their profession was uniquely practiced in this new setting.

Another respondent in essence repeats this point of view saying that during the ". . . Officers' Basic Course, a part of the time could be devoted to providing some specific orientation to consultation within the Army Mental Health setting. During this period, an emphasis could be made upon the theory and concepts of command consultation." This suggestion that practitioners might have been better prepared for their command consultation role was not the opinion of all respondents. This respondent's disagreement with this issue was brief and pointed: "By being born 15 years later." This respondent's remark had both a sarcastic and facetious implication, and at the same time, there was a note of earnest realism because during the early years of

command consultation, few individuals knew about this practice function and there was nobody to help. "In similar situations today," he added, "I could probably find all kinds of courses, books, consultants, and advice."

Another respondent underscored this idea with the following:

> I didn't know enough about the Army. At that time, we didn't have any "models" like Caplan. We were the Johnnie Appleseeds of Mental Health, spreading it all over the place.

But interestingly, the "Johnnie Appleseeds" were not unique innovators of the fifties who were subsequently replaced with experienced and prepared command consultants of the sixties. Quite the contrary, practitioners in the late sixties were still groping for and discovering the consultation modality, just as their older colleagues of the previous decade had done. A respondent made this point quite clear:

> We began command consultation spontaneously at the CTF (Correctional Training Facility, Fort Riley, Kansas) in 1968 really not knowing the concept or what we were doing. Later, of course, we found out.

The uncertainty of what was expected of an individual in the command consultation role was pervasive. This was a repetitious theme frequently emerging within the context of how respondents could have been better prepared. These comments were representative:

> I wasn't sure of what I was doing or what was expected of me. My superiors, especially social work supervisor, were equally unsure of our task, role and responsibility.
>
> A better understanding of precisely what my role really was in this matter and how would my involvement protect

> the client or place him in a risky position professionally. I would have liked a clear legitimatization of the role.

Some respondents felt that the preparation they received was very adequate and that the course of their total experience provided sufficient background so that they could successfully engage in command consultation. These comments dramatize this point of view:

> Only thru experience does one really feel prepared. Certainly, there are times when you never feel totally prepared but one forges ahead anyway.
>
> My supervisor, though twenty years a military social worker, was an extremely adequate teacher.
>
> I don't think that I could have been better prepared.

Another factor relating to how well social workers are prepared for command consultation has to do with their professional social work orientation prior to entering the Army social work program. The professional orientation of most social work practitioners is formulated by graduate social work education. Several respondents indicated that in order to fully understand and engage one's self in command consultation practice, group work or community organization should be an integral part of one's graduate social work education. One respondent stated directly that ". . . my social work training, i.e., casework, was deficient in this regard. A knowledge of group work or community organization is quite basic to effective practice of command consultation." A question posed to all respondents in the full scale survey had to do with the emphasis of each individual's study

sequence in their respective graduate schools. As previously shown in table 7, just 5 percent of the respondents reported that community organization had been the emphasis of their study sequence, and only 7 percent noted that group work had been stressed in their respective programs. It is significant that while individuals are saying command consultants should be well informed about group and community practice, just 12 percent of the practitioners actually possess such specialized familiarity. It is therefore understandable that with the majority of social work practitioners having a case-work orientation, command consultation energy would vacillate throughout the years of the program's existence.

Another idea expressed in the pilot survey was that effective command consultation involvement is more than learned; "it requires an intuitive feel for the process." If this idea were valid, it would have serious implications in terms of who could ultimately engage in the actual practice of command consultation. If, indeed, command consultation were more than a learned process, this would seriously limit the field. This question, therefore, was put to respondents in the full scale survey: "It has been suggested that in order for practitioners to do command consultation effectively, an 'intuitive feel for the process' is essential. What is your view?" Seventy-seven percent of the respondents indicated that they agreed with the suggestion that "an intuitive feel for the process" was necessary to engage in

effective command consultation activity. Only 23 percent of the sample disagreed. The implicit idea about a skill being intuitive is that it is natural and cannot be taught. In the same vein, a respondent added this thought: "These skills are being built into the personality traits. Some social workers will never be able to do consultation despite having a wealth of knowledge or education."

With such a strong majority of respondents perceiving that effective command consultation practice is basically intuitive, it becomes somewhat clearer that the practice of this preventive approach was in reality quite sporadic. Certainly, who could find fault with an innovation that had so much merit and possessed the valued characteristics found to be so desirable to professional social workers?[2] In fact, it was predictable that a positive reply would flow from this question that was put to the respondents: "Should any professional Army social work officer be knowledgeable about and capable of performing command consultation if called upon to do so?" The response was 86 percent saying "yes" and 14 percent saying "no." Thus, the paradox is presented: On the one hand, practitioners expected most of their colleagues to be capable of doing command consultation. On the other hand, they believed that the method presented a significant limitation in that it required innate, intuitive skills to engage successfully in the practice.

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[2]A detailed discussion of the characteristics associated with command consultation follows at a later point in this chapter.

The comments and experiences described above reflect diversified points of view regarding the way social workers felt prepared to engage in the innovative practice known as command consultation. These comments also show that respondents held many opinions about ways in which they might have been better prepared. It is clear that preparation was a spontaneous, informal and haphazard process. Under such conditions, it is not surprising that an innovative effort such as command consultation might be less likely to succeed when important aspects of the process such as preparation are left to chance.

Attitudes Toward Command Consultation

Just as learning about and engaging in the actual practice of an innovation are important stages in the practitioner's decision to accept or reject, attitude is also a critical factor in the establishment of a new idea. In the opening statement of this research, it was stated that command consultation was believed to be ". . . widely valued and highly regarded by those military practitioners familiar with it." In order to verify the accuracy of this assumption, respondents were asked how they reacted to the concept of command consultation when they first learned about it. Not surprisingly, 95 percent stated that it was acceptable, and just 5 percent thought it was unacceptable. When asked to comment on the reasons for their answers to this question,

respondents who thought command consultation to be acceptable cited the following overall themes:

...Command consultation is an effective preventive system.
...Command consultation is a valuable approach to problem solving.
...Command consultation is compatible with social work skills.
...Command consultation is a useful vehicle for social work to function outside of the medical arena, i.e., psychiatry.

Those who thought command consultation to be unacceptable commented as follows:

...Engaging in command consultation felt threatening.
...Command consultation was not accepted by users.
...Practitioners were not prepared to do command consultation.
...Command consultation was not an applicable/viable concept.

Respondents were asked if their attitude toward command consultation changed as time passed. Fifty-nine percent indicated that their attitude did not change while 41 percent noted a change. Of the 65 actual respondents who said their attitude toward command consultation changed, 44 individuals said their attitude was heightened and 19 respondents said their attitude was dampened. Respondents were then asked to what they attributed these changes. Those individuals who said that their attitude toward command consultation heightened had these comments:

...Command consultation brought results.
...Command consultation was invaluable in terms of prevention.
...Command consultation was recognized and accepted by commanders.
...Command consultation was a total systems approach providing complete knowledge of the organization as well as the troubled soldier.

...An increasing theoretical understanding made command consultation a highly useful practice approach.

The relatively small percentage of respondents whose attitude became less favorable over time made these well founded comments:

...There was no means for valid evaluation of command consultation.
...There were technical problems doing command consultation.
...Command consultation had too many limitations.
...The practice of command consultation was a myth.
...The preparation for engaging in consultation practice was totally inadequate.
...The practitioners were usually inexperienced.
...The attitude of the consultee was unfavorable and unaccepting.

On the basis of the preceding data and the general thrust of respondent comments, it is evident that social work practitioners in the MHCS regarded command consultation in a highly positive manner. If one were to design a strategy directed at introducing change in a social system, one of the most obvious steps would be to insure that a positive attitude among the target recipients of the change be induced. In the case of command consultation, there was apparently never any need to design any such strategy because the positive outlook toward command consultation already existed. Because it was virtually a given fact, few social work practitioners questioned its merits. Further, from the individual accounts of the respondents, positive attitudes toward command consultation was transmitted into actual adoption of the practice by the respondents during various stages of their social work, military experience. Respondents claimed they practiced it, succeeded in their effort, and received satisfaction.

Often in the case of an innovation, attitude and overt behavior are not necessarily correlated and there are numerous instances where attitudes and actions are quite disparate. However, in terms of the individual practitioner and his involvement with command consultation, there does not seem to be a great deal of reported dissonance.

What might help to describe the problems of command consultation more precisely would be to say that it suffers from discontinuity. While it is proclaimed to be a proper function for practitioners and users alike, its actual implementation ceases after individuals have adopted and practiced it for a period of time. Command consultation appears briefly but, after a short lived presence, dies out only to reappear elsewhere. In order to more critically analyze what causes the sporadic practice of command consultation, it is necessary to explore the broader historical question of command consultation's general development.

State of Command Consultation's Overall Historical Development

The focus of the discussion to this point has been on each respondent's individual experience with command consultation. This has been an exploration of the respondents' subjective statements of their own particularized learning, preparation, and practice of command consultation. The discussion will now shift to how the respondents perceive the more general issue of command consultation's broader development.

A series of three questions were put to the respondents in order to obtain information about how they perceived the overall development of command consultation throughout the mental health services in the U.S. Army. The respondents were asked to relate their general impressions of (1) the extent to which command consultation was practiced, (2) the degree to which command consultation was understood, and (3) the level of success that command consultation had achieved during the course of its development. It was understood that the individual experiences of the study sample were limited to specific times and places. Therefore, respondents were instructed only to answer for the time periods during which they either had association with or knowledge of command consultation.

The first issue that respondents were asked about was to identify the "extent to which they believed that command consultation was generally practiced by most Army social workers during the time periods ranging from the 1950s through the early 1970s." Respondents were requested to select one of these four response options: "widely practiced," "occasionally practiced," "rarely practiced," and "not practiced." The findings are presented in table 13 on the following page.

The data in table 13 indicate that practice levels of command consultation were perceived by respondents to be at their highest level in the 1960s. The understandably limited

TABLE 13

EXTENT TO WHICH COMMAND CONSULTATION WAS PRACTICED BY MOST ARMY SOCIAL WORKERS DURING SELECTED HISTORICAL TIME PERIODS

Time Period	(N)*	Widely Practiced	Occasionally Practiced	Rarely Practiced	Not Practiced
Early 1950s	52	10%	33%	17%	40%
Late 1950s	65	19	49	12	20
Early 1960s	86	28	52	11	9
Late 1960s	138	25	56	14	5
Early 1970s	84	19	46	15	19

*Data in the above table represent percentages based on actual number of respondents reporting applicable Army social work experience during each respective time period.

levels of practice in the early 1950s is undoubtedly associated with the fact that the innovation was in its inception at this time. However, the steady decline in levels of practice in the early 1970s attracts one's attention. Command consultation was reported by 19 percent of the respondents to be "not practiced" in the early 1970s; this figure compares with the 20 percent who believed it was "not practiced" twenty years earlier. As one of the respondents commented, command consultation was almost like "old wine in new bottles." Another respondent commented in the margin of this question, strongly underscoring the state of command consultation's discontinuance in the early 1970s: "And I can verify this situation. I travel all the time looking at programs. We are just not doing it." Still another respondent

who checked the response choice "not widely practiced" in every time period had this to say: "There is much that is verbalized about the practice of command consultation, but there is little in actuality.

The second question put to the respondents was the following: "To what extent do you think command consultation was generally understood by most Army social workers?" Again, four response choices were provided: "largely understood," somewhat understood," "somewhat misunderstood," and "largely misunderstood." Table 14 shows the data results obtained for this issue.

TABLE 14

EXTENT TO WHICH COMMAND CONSULTATION WAS UNDERSTOOD BY MOST ARMY SOCIAL WORKERS DURING SELECTED HISTORICAL TIME PERIODS

Time Period	(N)*	Largely Understood	Somewhat Understood	Somewhat Misunderstood	Largely Misunderstood
Early 1950s	51	14%	37%	25%	24%
Late 1950s	64	19	50	19	12
Early 1960s	86	23	52	14	11
Late 1960s	137	26	46	22	6
Early 1970s	83	21	42	24	3

*Data in the table represent percentages based on actual number of respondents reporting applicable Army social work experience during each respective time period.

Table 14 shows that in the early years of command consultation, levels of understanding were at the lowest point. A progressive rise in understanding took place through the

latter half of the fifties and during the sixties. It reached its peak in the mid-sixties before tapering off in the early 1970s. It is interesting to observe that the heaviest response category is in the range of "somewhat understood." Command consultation was indicated by 52 percent of the respondents as somewhat understood in the mid-sixties, while 23 percent noted that the innovation was "largely understood" during this period. The increasing percentages of respondents who reported a rise in misunderstanding regarding command consultation during the early 1970s is to be noted.

The third question put to the study sample was: "How do you evaluate the overall development of command consultation?" Respondents were asked to answer in one of the following four categories: "highly successful," "somewhat successful," somewhat unsuccessful," and "highly unsuccessful." Table 15 presents the findings for this question which covers the time frame of the early 1950s through the early 1970s.

The data in table 15 indicate that most respondents did not decisively rate command consultation's overall development as either highly successful or highly unsuccessful. Rather, the largest scores appear in the less definitive positions of "somewhat successful" and "somewhat unsuccessful." Moreover, the category emphasized by respondents is "somewhat successful." Based on this data, respondents

TABLE 15

LEVEL OF SUCCESS REGARDING OVERALL DEVELOPMENT OF COMMAND CONSULTATION DURING SELECTED HISTORICAL TIME PERIODS

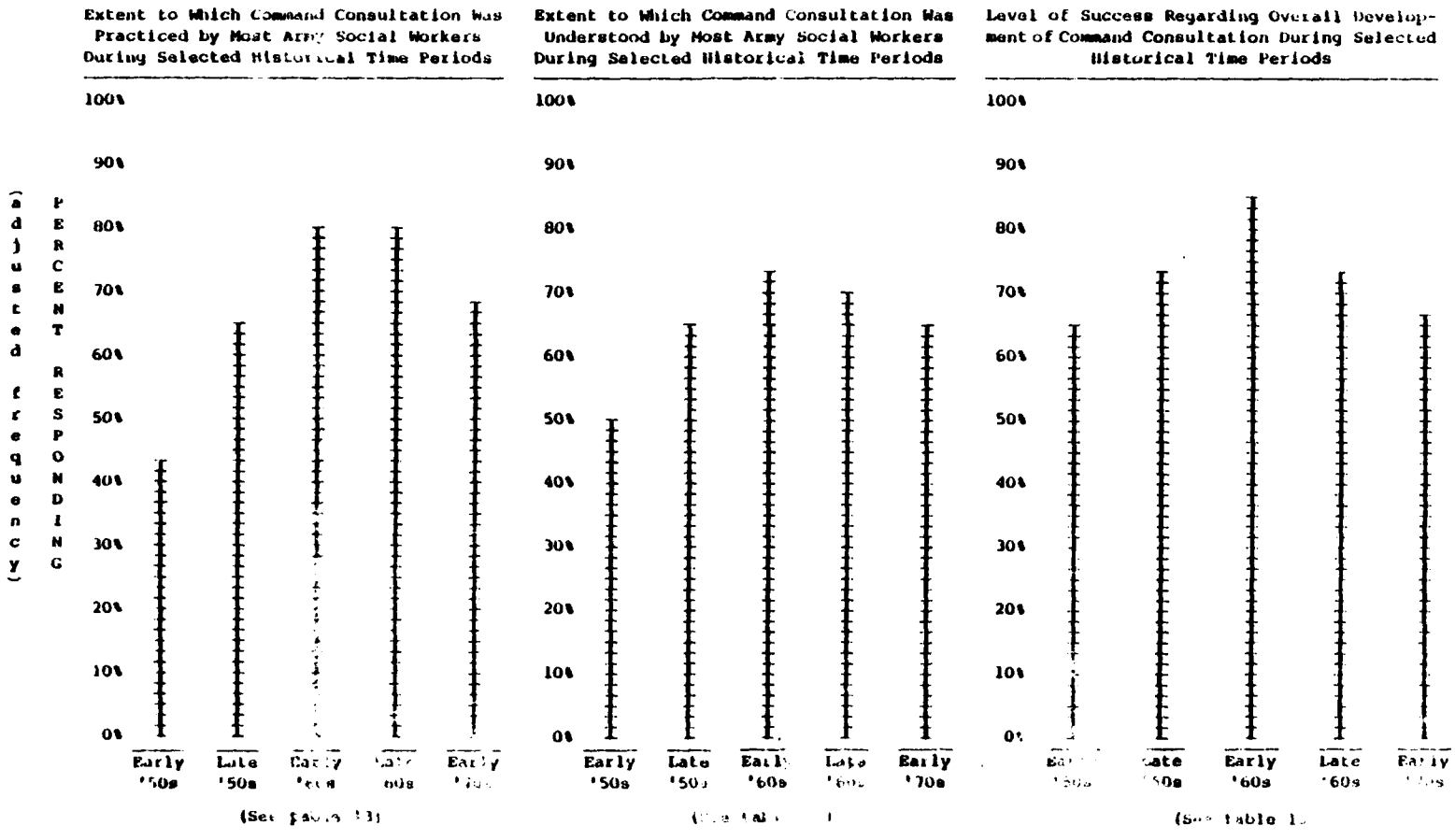
Time Period	(N)*	Highly Successful	Somewhat Successful	Somewhat Unsuccessful	Highly Unsuccessful
Early 1950s	48	11%	56%	25%	8%
Late 1950s	60	12	67	18	3
Early 1960s	84	29	57	11	3
Late 1960s	137	18	58	20	4
Early 1970s	79	12	57	20	11

*Data in the above table represent percentages based on actual number of respondents reporting applicable Army social work experience during each respective time period.

perceived that the command consultation movement was more successful than unsuccessful. One respondent commented on this question, giving caution to the degree of credence that can be placed on how social workers rate the relative success of their own programs. This respondent bluntly put it this way: "Social work officers tend to BS about their success. I need to rely on research." Figure 2 offers the reader an alternate way to examine the data presented in Tables 13, 14, and 15. Within each of the three questions, response categories were combined from four to two categories. For example, "largely understood" and "somewhat understood" were condensed into "understood," and "somewhat misunderstood" and "largely misunderstood" were stated as "misunderstood."

FIGURE 2

OVERALL LEVELS OF UNDERSTANDING, PRACTICE, AND SUCCESS
THAT COMMAND CONSULTATION ACHIEVED HISTORICALLY



The graph's configuration clearly depicts a rise in the development of command consultation beginning in the early 1950s through the mid-sixties followed by a decline into the early 1970s. The pattern distinctly increases, peaks, and decreases in relation to all three issues: practice, understanding, and success. Examination of the curve reveals that the state of command consultation's overall development in the 1970s as represented by the three issues is practically at the same level as in the 1950s—dramatic evidence to reflect the rise/decline and ultimate stagnation of the innovation.

Nature of Command Consultation

Thus far in this chapter, the focus has been upon the experiences that social work practitioners have had with command consultation and with the state of command consultation's overall development. Attention now is directed toward defining command consultation and identifying the characteristics that it possesses. The clarity of an innovation and manner in which receivers sense or perceive its characteristics has an important effect on the rate of adoption. Command consultation itself has a varied combination of attributes that may be beneficial to its progress and drawbacks which could impede or retard its advance. The following discussion will examine the definition of command consultation and explore respondents' understanding of the principles

associated with it. Specific characteristics such as command consultation's relative advantage, complexity, and compatibility, and the value associated with it will be studied.

Defining Command Consultation

One of the most perplexing issues raised in this research had to do with command consultation's definition. It was believed that a significant part of what went wrong with command consultation had to do with widely disparate ideas among social work practitioners over what was the essence of command consultation. Judging from the comments of respondents regarding their understanding of command consultation, this initial assumption seemed to be [illegible]. One individual said it very well as reflected by the following observation:

> It has been my experience that the concept of command consultation differs widely among most social workers and this divergence needs to be known . . . . When I speak of command consultation, I definitely know what I am talking about. This is probably true of your other respondents. But, the 64 dollar question is--"Are we talking about the same thing?"

Respondents in the full scale survey were not provided with a definition of command consultation. This strategy was designed to enable respondents in the full scale survey to freely and openly explore their understanding and interpretation of command consultation. Some individuals felt uncomfortable about not knowing what was specifically meant by command consultation. One respondent stated the following: "You seem to assume that respondents know what is meant

by command consultation and I'm not sure that's true. I'm not aware of having truly practiced what I thought to be command consultation!" The uncertainty that this respondent felt regarding the definition of command consultation dramatizes the underlying problem hypothesized in this study, i.e., there is a lack of consensus or agreement regarding what command consultation comprises. The subsequent comments illustrate how some respondents defined command consultation:

> Command consultation is apprising the commander of psycho/social conditions which may affect his unit's functioning and make recommendations when required.
>
> Command consultation seems to be a way of enabling Command to become more aware and involved in unit problems.
>
> Command consultation is a process of shared thinking at the field and general levels of command, usually taking place at the Command Post, wherever it may be located.
>
> The working together of mental health personnel with commanders at the unit level on problems which are experienced with troops by command or troops along.
>
> Command consultation is a service of an MHCS program. Operationally it is provided by a MHCS team consisting of a social worker officer or psychologist as team leader, a number of social work/psychology technicians and a consultant psychiatrist. The services provided are diagnosis, treatment, and consultation . . . . Consultation is provided in a group setting though it can be a less formal process, i.e., a one to one experiential situation. The focus of the consultant is not treatment but rather a helping process focused on assisting the consultees to deal with their problems more effectively.
>
> In terms of definition of command consultation, in my three years, I never once saw such principles in writing—definition was an informal process.

> My concept of command consultation is that of providing consultation to unit commanders by mental health professionals, to assist that commander in his decision making; providing input when appropriate. The consultation may by case centered . . . or centered on areas of more general concern, such as how to effect improved morale.
>
> Command consultation entails a clearly defined process with specific goals to advise troop commanders on matters that relate to the psycho-social adjustment of military personnel. Its fundamental thrust is preventative in character, i.e., counseling an officer on signs and symptoms of behavior disorders, training officers in techniques of interviewing and counseling. Moreover, command consultation involves the process of diagnosis and treatment of emotional disorders.
>
> A mutual process between command and mental health staff to assume optimal opportunity for individual growth within the military framework. The consultation can be in terms of system development assisting command in more fully understanding a particular soldier, serving as a catalyst in conjoint sessions between unit members, offering staff development programs, e.g., experience groups for officers, NCOs, enlisted men.
>
> Command consultation was the practice of keeping abreast of the effects, positive and negative, of command decisions on general morale of the men in a particular unit or the post as a whole. It consisted of keeping top level command advised as to the needs, problems of the soldier. Making recommendations was an inherent part of the consultation.

These definitions were drawn from social workers who were initially interviewed in the pilot phase of this study. As explained in the methodology chapter, these individuals were selectively chosen for the pilot interviews because of their specific knowledge and experience with command consultation. In short, this group is representative of the most informed individuals with regard to command consultation. Still, their statements about command consultation reflect some diversity and inconsistency. The operational definitions

presented by these Army social workers contained the basic elements of an overall definition for command consultation. These elements were examined and merged with many of Rapoport's theoretical concepts regarding consultation. From these two sources, i.e., Rapoport[3] and the respondents in the pilot interviews, the following composite definition was established as a baseline for analyzing further data in the full scale study.

Composite Definition of Command Consultation

Command consultation is a process whereby mental health personnel (1) act primarily through the medium of the command structure in (2) assisting it toward a better utilization of resources so that conditions necessary for (3) optimum social functioning might be obtained for (4) the individual, group, and/or organization. The focus of the consultant is on (5) primary prevention, that is, eliminating ineffectiveness or dysfunction before it occurs. Command consultation normally takes place (6) within the environment of the consultee who is (7) free to accept or reject feedback and/or options which the consultant offers. The consultant does not have responsibility for (8) direct action regarding the presenting difficulty, (9) nor is he responsible for the actions of the consultee. (10) The consultant does not give advice or recommendations per se and is (11) not an internal

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[3]Lydia Rapoport, Consultation in Social Work Practice (New York: National Association of Social Workers, 1963).

or administrative part of the system; rather, the consultant is outside the chain of command. The primary manifestation of the consultant's role is (12) non-directive and the involvement with the organization is a (13) time limited function. The main concerns of the consultant have to do with (14) enhancing communications and decision making within the system, resolving conflict, clarifying work related roles of personnel, engaging in goal setting and problem solving, and developing team cohesiveness. Command consultation may take on (15) a variety of forms such as program consultation, case consultation, administration consultation, unit group consultation, educational consultation, etc.

The issue of defining command consultation was also put to the respondents in the full scale survey and it was expected that a still wider span of disagreement would be reflected by this group in comparison with the interviewees in the pilot survey. This question was posed to the social workers participating in the full scale study: "How do you think the principles associated with command consultation have been defined?" Nineteen percent of the respondents thought that the principles of command consultation were "well defined"; 81 percent, however, indicated that the principles were either "somewhat defined" or "poorly defined." These results give a rather general impression that the majority of Army social workers did not perceive that command consultation principles were particularly well defined. In order to obtain a more specific accounting of what the

respondents themselves actually knew about the principles of command consultation, they were asked this question: "Please list the primary principles which you identify with command consultation." In all, 135 respondents listed over 517 items which delineated their understanding of some concepts relating to command consultation; 28 respondents omitted the question.

The method for analyzing these 517 principles of command consultation that the respondents identified was to compare the principles with the composite definition presented on the previous pages. Overall, 49 percent of the principles were evaluated to be consistent and congruent with the baseline definition. Such consistency was reflected by some of the following examples:

Respondents' List of Principles Compatible with Composite Definition	Corresponding Principle in Composite Definition
a. Mental health is a function of command.	#1
b. Maximum output for minimum input.	#2
c. It is cheaper to prevent than to treat.	#5
d. Deal with every level of the system.	#4
e. Consultant is outside the chain of command.	#11
f. Relationship is temporary in nature, visualized as having a terminal phase.	#13
g. Gives consultee a range of choices for his approval or rejection	#7

This partial list of principles is representative of 253 total principles that were considered consonant with principles in the composite definition. In all, 100 respondents or 67 percent of the total study sample contributed one or more of these principles that were judged compatible with the baseline definition. These data suggest that a relatively significant portion of the sample had at least a basic understanding and knowledge of one or more of the principles associated with command consultation.

Returning to the total of 517 command consultation principles identified by the respondents, 51 percent of these principles were deemed superfluous, lacked congruity or were indicative of other mental health practice functions with no particular or specific application to command consultation per se. Illustrations of principles presented by respondents which were categorized as not relevant follow.

Examples of Principles Listed by Respondents That Were Not Compatible With Composite Definition

a. Knowledge of basic Army jurisprudence and civil law.
   Awareness of lines of authority.
   Awareness of personnel management goals.

b. Assisting command to achieve its mission when consultation can help to feret out "sick" individuals and/or units.

c. Adapt casework principles to consultation process.

d. Identifying problems and situations having negative impact; assist in correcting this.

e. Early diagnosis, early treatment.

f. Detection, diagnosis, treatment, long term management. follow through.

g. Assisting command to carry out mission.

h. Maintaining and advocating the needs of the individual involved.
Must be willing to express one's beliefs about a situation.

i. Education, referral, treatment.

Several respondents stated that they could not recall any specific command consultation principles and another individual mentioned this: "I don't associate principles with command consultation." Still another subject said: "I don't think the principles are defined enough to be listed, i.e., they are at a more philosophical stage and not clearly conceptualized."

As previously noted, 28 respondents chose to [illegible] above question. Thus, this sampling of principles represents 236 total principles that were regarded to be superfluous or were incongruous with the principles in the composite definition. Of the total study sample, 109 respondents or 67 percent mentioned one or more principles of command consultation that were evaluated to be <u>incompatible</u> or incongruous with the baseline definition. In contrasting this statistic with the 110 respondents or 67 percent of the total study sample who contributed one or more principles judged to be <u>compatible</u> with the baseline definition, the reader is reminded that each individual may have listed several principles so that the totals therefore surpass the 163 subjects in the sample and the 100 percent figure that would otherwise result.

There was a tendency among many respondents to generalize some basic principles of the social work profession to principles of command consultation practice. Examples of these were "dignity of the individual," "self determination," "conscious use of self," etc. While these principles are compatible with command consultation, the tendency for respondents to relate to these principles rather than to those in the composite definition indicates a limited awareness of command consultation as a distinct practice function with its own specialized techniques, methodologies, and applications.

In several cases, respondents presented lists of five or more principles that were all consistent with those presented in the composite definition. In these instances, it was clear that such respondents knew clearly what they were talking about when they were speaking of command consultation. Moreover, in the process of presenting these comprehensive principles, these respondents were in effect formulating their own composite definitions of command consultation which had substantial consistency with the model baseline definition presented earlier. Two examples of such definitions follow:

> The consultee is not a patient or client. The purpose of consultation is to help the consultee with a problem that he is struggling with and requests assistance for. The relationship is based on equality not like the doctor/patient relationship, i.e., one up. The explicit purpose of command consultation is problem solving for more effective organizational functioning.

Regular, planned contact from MHCS staff with key command figures to open communications and prevent problems.

At least ten respondents referred to Gerald Caplan's teachings about mental health consultation. The following was a representative comment: "Same principles as apply for any mental health consultation, as well spelled out in Gerald Caplan's book, Theory and Practice of Mental Health Consultation."[4]

It is clear that most respondents perceived command consultation as an expanded function for mental health practitioners that takes place in the field with the cadre or commander of the troubled soldier. Most subjects understood command consultation as a preventive approach that is directed to the benefit of the individual and/or organization. The degree to which respondents differentiate command consultation's emphasis from the individual to that of the organization was an issue the full scale study addressed. Respondents were told that "two types of command consultation are most commonly identified: case consultation and unit consultation." Study subjects were then asked "which type of command consultation they had most often practiced." The majority of subjects, 53 percent, said that they practiced "case consultation" most often. Just 12 percent indicated that they

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[4]Caplan's writing on the subject of mental health consultation was widely known and regarded by community mental health proponents in Military Psychiatry and Army social work practice. The text mentioned above is published by Basic Books, Inc., New York, 1970.

engaged in unit consultation; 35 percent, however, noted that they practiced each form of consultation "equally." These subjective accounts of the kind of consultation practiced by respondents was relatively consistent with the kinds of principles they associated with command consultation. Those respondents who indicated that they engaged in case consultation widely emphasized the issue of working on soldiers' problems with commanders in the field. In contrast, subjects whose primary involvement was unit consultation spoke about broader systems type interventions such as working on "organizational issues."

To review, a wide spectrum of viewpoints existed in relation to how command consultation was defined and to the basic principles associated with this practice function. The importance of this discussion has to do with evaluating the extent that it affected the diffusion of command consultation in the Army's MHCS. Respondents commented that command consultation meant different things to different people. Individual accounts revealed that not everyone was totally clear with regard to the various elements of command consultation's definition and principles. However, the survey data also indicate that a basic core of understanding existed among most respondents with regard to the essential principles that comprised command consultation. Respondents almost universally understood that command consultation was (1) a broad organizational approach that (2) involved commanders,

and they perceived that it was (3) a primary prevention approach. Many respondents asserted that there was no consensus regarding the basic principles of command consultation, yet, they seemed to be saying that they themselves had a basic grasp of the essence of command consultation. It might be concluded that a consistent definition and delineation of command consultation principles never diffused throughout the system; however, it would be ill-advised to conclude that command consultation failed for this reason alone. There are simply too many individual accounts of respondent familiarity with the principles underlying command consultation to make such an assertion. The reasons for command consultation's decline would seem to lie only in part in the issue of definition.

Characteristics of Command Consultation

During the initial pilot phase of this research, interviewees identified a broad range of characteristics which they associated with command consultation. Inevitably, these subjects spoke about these characteristics in terms of whether they were advantageous or disadvantageous to the evolution of command consultation. Rogers's definition of relative advantage as it is associated with Innovation Theory was used in compiling and categorizing the issues;[5] relative

[5]Rogers, Ibid., p. 11.

advantage, thus was seen as the degree to which command consultation was perceived by social workers as having greater value and benefit than other practice functions in the MHCS. In the procedure, then, of categorizing the issues, ten items were grouped together and later presented to the respondents in the full scale study as issues considered by some Army social workers that interfered in the successful implementation of command consultation. A contrasting group of seven items was organized in another series of questions and presented to respondents as reasons considered to be valuable attributes in the practice of command consultation. In the questions containing these contrasting groups of issues, respondents were asked to identify the degree to which they perceived the items as advantageous or disadvantageous to the practice of command consultation. Analysis and discussion of the data pertaining to these issues follows.

Issues Disadvantageous to Command Consultation Activity

The following statement was posed for respondents in the full scale study: "The following items have been considered by some Army social workers to interfere with the successful implementation of command consultation programs. Read each item carefully and indicate the degree to which you think it may interfere with command consultation activity." Response categories for this question were "strongly interferes," "moderately interferes," "slightly interferes," and

"never interferes." Table 16 indicates the percentage of individuals who responded in the various categories, and it also presents a rank ordering of these items in relation to the degree each was believed to have interfered with the successful implementation of command consultation.

Experience as a Characteristic

The item identified by the study group which most strongly interfered" with the successful implementation of command consultation programs was the "limited experience of mental health personnel doing consultation." Earlier in the study when respondents were called upon to account for their own experience with command consultation, they reported high levels of experience, preparation, knowledge, success, and satisfaction. Yet, when considering the greatest obstacle to command consultation's successful implementation, respondents indicated that it was the experience factor of their colleagues that was lacking. The responses seem to indicate that individuals prided themselves on being substantially involved but believed that other mental health personnel were generally unprepared to carry on consultation; simply, each individual was saying: "I was doing command consultation but no one else was!" And in truth everybody who says they were doing command consultation undoubtedly was involved from time to time and engaged in the process in an isolated fashion. All this is indicative of the sporadic nature of command consultation's evolution. Given such an inconsistent course of

TABLE 16

ITEMS PERTAINING TO COMMAND CONSULTATION BELIEVED TO BE DISADVANTAGEOUS TO ITS SUCCESSFUL IMPLEMENTATION

Items Believed to Interfere With the Successful Implementation of Command Consultation	(N)	Percentage of Respondents Perceiving Strong to Moderate Interference	Percentage of Respondents Perceiving No Interference To Slight Interference
Limited experience of mental health personnel doing command consultation	161	83%	17%
Frequent assignment rotation of staff disrupts continuity	162	75	25
Staff feel a stronger commitment to working with the individually troubled soldier than with consulting to commanders	161	73	27
Unwillingness of commanders to use consultation services	158	70	30
Bureaucratic, organizational constraints	161	48	52
Command consultation is complex and difficult to do	157	44	56
It is threatening to consult with higher ranking commanders	160	43	57
Rewards for doing command consultation not readily observable	160	34	66
Engaging in command consultation is elitist	158	13	87
Command consultation is not consistent with the traditions of social work practice	158	9	91

NOTE: The data represent adjusted percentage frequencies. Items are in rank order.

of development, it is understandable that the program did not achieve the success that was envisioned.

Continuity

Respondents identified the characteristic labeled "continuity" as the second most important factor that interfered with command consultation's successful implementation. Respondents presented this as an administrative constraint noting particularly that the "frequent assignment rotation of staff disrupted continuity." The point of view reflected here is a realistic appraisal of a basic fact of military life: that is, personnel receive frequent and often unanticipated transfers. The impact as it has affected command consultation is as follows: To begin, mental health practitioners typically hear about and proceed to develop a command consultation component to their MHCS programs. At a critical juncture in the course of such development, the key practitioner or individual most committed to the task receives an assignment transfer. Because an institutionalized basis for continuing the program does not exist, newly assigned practitioners designated to replace those departing normally do not possess familiarity with command consultation. The consequence is that these new individuals who take over the program often elect to dispatch the idea in favor of a more familiar function such as clinical contacts. The process of eliminating the program may take place by deliberate, conscious choice or through simple and benign

neglect. In any case, programs rise and fall with the coming and going of the people who have familiarity and knowledge of it. This is not considered an especially conducive factor that would lend itself favorably to the successful diffusion of an innovation.

Psychological Commitment to the Individual

The factor which respondents identified as the third most significant force disadvantageous to command consultation's successful adoption was as follows: "Staff feel a stronger commitment to working with the individually troubled soldier than with consulting to commanders." Of the study participants, 73 percent perceived "strong to moderate interference" while 27 percent perceived "no interference to slight interference." This commitment to the individual is very consistent with a primary social work value that the needs of the individual are of paramount concern to the practitioner. However, the fundamental principles of command consultation do not directly identify the individual as the central area of consideration. The primary principles of consultation focus on the system, on prevention, on the consultee, on the environment, or on social treatment goals. On critical examination, these areas of concern are also of great importance to social workers. And yet, when respondents were required to choose between the system or the individual, they were decisively inclined to choose the

individual. There is an emergence of dissonance between what social workers inherently feel their role ought to be and the creation of a new practice function which emphasizes a greater, more significant social treatment objective. The inconsistency is dramatically illustrated by data presented later in this chapter which shows how universally social workers pride themselves on "valuing command consultation."[5] However, when presented with the dilemma of juxtaposing their commitment to command consultation against a clear diminution of the status of the individual, the respondents rally faithfully around their instinctive, professional commitment to the individual. Community organizers or community planners within the social work profession might hold the view that working on a macro or system level does not in any way sacrifice the needs of the individual. These social workers could present a strong case pointing out that the needs of the individual might be most effectively met indirectly by working on the level of the larger organization. From this standpoint, the individual will ultimately benefit the most; therefore, it could be logically argued that there is really no inconsistency. The fact is, however, that the disproportionate majority of respondents in the study happen to be casework oriented and the data strongly indicate that these respondents perceive dissonance. If more Army social work

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[5]It is reported on pages 159-160 of this chapter that 93 percent of the study respondents believe command consultation to be consistent with social work values.

practitioners actually had a stronger graduate school emphasis on community rather than casework, this dissonance might be lessened.

In summary, this question dramatizes that the innovation known as command consultation was not simply a presentation of a new approach to working with people; on the contrary, it changed a basic value held by the majority of practitioners, i.e., the needs of the individual supersede the needs of the system. How then could command consultation have been expected to succeed if such a critical alteration were put to such a select group of social workers, i.e., casework practitioners?

Compatibility with
Client Needs

The issue that respondents ranked fourth in interfering with the diffusion of command consultation was the "unwillingness of commanders to use consultation services." Responses indicated that 70 percent thought that this issue either moderately or strongly interfered with the successful implementation of command consultation; 30 percent stated that it only interfered slightly or did not interfere at all Several respondents chose to comment on this topic:

> Much consultation is provided when it is not requested or desired by the commander. The value and effectiveness of such a resource as command consultation is frequently not appreciated or understood by commanders.

This social worker was asserting a fundamental problem that could have well interfered with the successful implementation of command consultation. He cited the viewpoint that a basic anti-mental health orientation exists among numerous line

commanders and staff officers in the Army. Another respondent noted, ". . . it is essentially the preference of expediency to human values." More directly, this responder identified the commander's chief concern: i.e., "get the mission accomplished, and deal with people's feelings later."

This point of view was not held unanimously among the respondents in the study sample. A contrasting position was presented as follows:

> I realized that it was the commander who was responsible for the troops and that he was the one that had to be influenced if I was to make any impact on the unit. I think the atmosphere and attitude of command towards command consultation and the MHCS was supportive of the concept and approach.

The comment of still another respondent suggests that the problem of command consultation's acceptance vis-a-vis the commander may have been part of the relationship building process: "Be a coffee drinker," this participant said. Implicit in this individual's comment is the idea that informal contact between consultant and commander is the primary ingredient needed to build a relationship of trust—a relationship which would in turn yield a successful command consultation outcome. This respondent stated the point succinctly:

> The effectiveness of or even presence of command consultation on a post is directly contingent upon the consultant involved. It is not so much related to what one knows, but rather how he gains an audience. Commanders sometimes view social workers and other MHCS personnel as "living in ivory towers" and professing highly idealistic values. Any consultant if he is to be effective, must speak the language of his consultee, be willing to dirty his hands in non-social work related activities, i.e., going out in

> the field with the unit and participate in parts of the training. This is how a relationship and a successful command consultation effort is reached.

Respondents expressed the additional belief that because the command consultation program was never formally institutionalized, few commanders ever knew that mental health personnel were ". . . in business to do anything but perform treatment services to individuals." Respondents stated that they believed most commanders perceived the MHC as a trouble-shooting clinic where individuals could be sent for therapy and/or administrative separation from the Army. One respondent put it as follows:

> . . . There were two things that most commanders knew about the MHCS. It was the place where you could get rid of your problems. Counseling was one of the services and "212s" were the other.

In referring to the 212s, this respondent was recognizing the fact that a series of regulations require the MHCS to be involved in the process of determining whether or not individuals are suitable for continued military service. Such determinations were based on reasons defined as either "non-medical" (character and behavior disorder), or "medical" (psychosis or organic). The result of this requirement was that the services of the MHCS became heavily centered on conducting routine mental status evaluations, thus not allowing MHCS practitioners the time to devote to field consultation services. As another respondent stated: "The MHCS was a '212' mill and few commanders ever knew that we did anything else." This point of view is consistent with an unpublished

report by an Army psychiatrist who found that half of the officers in an Armored Division were either totally unaware of the presence of an MHCS or had little knowledge of its mission. Those officers who did know about the MHCS held the belief that the most important functions in which practitioners engaged had to do with providing treatment, giving advice and assisting in the process of separating dysfunctional soldiers from the Army.[6]

The willingness or readiness of commanders to use consultation services is very much related to how they learned about the existence of such activities. In another portion of the full scale survey respondents were presented with a list of ways by which commanders normally learned about command consultation services. Respondents were asked to rank order the ways in which they believed commanders actually learned about command consultation, and they were also asked to rank order the ways in which they thought commanders should have learned about command consultation. Table 17 contrasts the results of these questions.

Table 17 reveals the informal manner by which commanders learned about command consultation. "Informal contact or exposure to mental hygiene staff" and "informal discussion with fellow company commanders" were ranked first and second in relation to the ways that commanders typically learned

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[6]Juan B. Sousa, "Command and Staff Viewpoints About Mental Hygiene Consultation Service in a European Armored Division" (Office of the Surgeon General, 1963).

TABLE 17

WAYS THAT COMMANDERS LEARNED ABOUT AND SHOULD HAVE LEARNED ABOUT COMMAND CONSULTATION

Method	Ranking of scores for ways commanders should have learned about command consultation	Ranking of scores for ways commanders have learned about command consultation
Briefing from battalion or brigade commander	1st	4th
Formal presentations by mental hygiene staff	2nd	3rd
Informal contact or exposure to mental hygiene staff	3rd	1st
Local directives, circulars, or regulations	4th	5th
Department of Army communications (circulars, ARs, training bulletins, etc.)	5th	6th
Informal discussion with fellow company commanders	6th	2nd
Post newspaper or publications	7th	7th

NOTE: Scores for each of the seven items were calculated by multiplying the ranking assigned to each item by the number of respondents giving that ranking.

about command consultation. Interestingly, this informal learning process patterns the informal way that respondents themselves learned about command consultation, already described in an earlier portion of this chapter. In analyzing

what respondents believe should have been the way in which commanders learned about command consultation, it is noted that they chose formal processes, i.e., "Briefings from battalion or brigade commanders" and "Formal presentations by mental hygiene staff." It is especially interesting to observe how respondents ranked the item having to do with "informal discussion that commanders had with their fellow commanders" in relation to learning about command consultation. Respondents indicated that this was the second most frequent process of exchanging information about consultation services. The respondents further stated that it "should have" ranked sixth in importance.

In further evaluating the implications of this data, it is suggested that informal learning methods may be suitable for those who happen to be in a position to receive the knowledge. However, if certain individuals are not exposed to an informal learning experience, it is probable that they will simply never have any opportunity to hear about it. Sousa conducted a study of officers and commanders in a U.S. Armored Division in Germany. Fifty percent of the respondents reported either a lack of knowledge of the division mental hygiene facility's existence or unfamiliarity with its purpose.[7] It is further implied in this study that the lack of a systematic, formal learning process could have been responsible. Thus, the informal processes of spreading the

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[7]Ibid.

word about command consultation was a method of chance and it seems apparent that it did not work.

Organizational Constraints

Bureaucratic and organizational constraints were ranked fifth by respondents in terms of factors that interfered with the successful implementation of command consultation. Bureaucracy, as presented by Blau and Meyer, is often perceived by critics ". . . as symbolizing red tape, inneffiiciency, and arbitrary domination of clients by insensitive officials."[8] The structural arrangements of the MHCS were seen by one respondent as having built in failure components that ". . . doomed command consultation's hopes for success from the very beginning." This respondent was referring to the fact that command consultation was often ". . . not understood by the hospital commander, his chief of professional services, or the executive officer." These officials were responsible for ultimately setting policy and granting approval to allow innovative ideas sufficient opportunity for development. While MHCS practitioners may have believed in the field consultation program, hospital officials who believed otherwise could stifle command consultation's acceptance. A respondent dramatized the point as follows:

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[8]Peter M. Blau and Marshall W. Meyer, Bureaucracy in Modern Organizations (New York: Random House, 1971), p. 119.

> The Chief of Professional Services never could understand how I (a social worker) could have operational control over the MHCS. When we tried to explain to him that our field consultation effort was achieving its objective by cutting back referrals to the clinic, he thought we were simply not doing our job. No amount of talk could convince him that our primary prevention program called command consultation was effective and producing the most beneficial results. Ultimately, when it came time for evaluations, we paid the price for sticking to our idealistic dreams.

And still another respondent had this to say on the same subject:

> Command consultation is not understood or accepted by the medical bureaucracy. In other words, the MHCS is goofing off if patients are not being seen in a clinic. Hospital commanders do not perceive mental health professionals as offering a required service, i.e., consultation.

Complexity

Respondents ranked the item "command consultation is complex and difficult to do" sixth in terms of its interference with the successful adoption of command consultation. The complexity of command consultation was indicated by 44 percent of the subjects as "strongly or moderately" interfering with the course of its introduction; 56 percent felt there was just "slight interference or no interference" at all with regard to its successful implementation.

Early in the development of the study, it was thought that the degree to which respondents perceived command consultation's complexity was an important item in the inquiry. Therefore, in order to further validate the respondents' view of command consultation's complexity, the question was also presented in another part of the full scale survey as follows:

"What degree of difficulty do you as a social worker associate with command consultation?" Fifteen percent of the respondents thought that command consultation was "very difficult to do," 38 percent considered it "moderately difficult" to do, and 22 percent considered it "somewhat difficult" to do. Thus, 75 percent of the respondents associated varying levels of difficulty with the practice of command consultation.

During the early conceptualization of this study, it was assumed that the extent to which any innovation is seen as being difficult to understand or to implement will normally influence its rate of adoption in a social system. In the present case of command consultation, it is clear that if practitioners thought it were complex and difficult to do, the likelihood of it being quickly integrated into existing systems of practice would be less than if it were easily understood and simple to implement. Therefore, if approximately 50 percent of the respondents thought that command consultation's complexity "strongly interfered" or "moderately interfered" with the course of its introduction, and 75 percent perceived some degree of complexity to exist, this may well explain the long term breakdown in practitioners failing to consistently engage in the activity.

In commenting on this subject, several respondents indicated that providing consultation services was relatively easy. One respondent noted that the skills required to

perform this activity "should be an intrinsic aspect of one's professional education." Another respondent noted that providing consultation service in a relatively healthy segment of the Army community was considerably "less complicated than dealing with the multiplicity of psycho-social problems in a treatment setting." Another subject stated that even if the social workers were unfamiliar with consultation activities, the function was basically one requiring a technical skill that was relatively easy to learn.

One respondent declined to dichotomize between the complexity or simplicity of command consultation practice. He said that consultation services were "unique practice functions that made allowances for a wide range of skills and educational levels." He thought that consultation services could be provided either on a highly sophisticated basis or in an elementary fashion. The respondent cited empirical illustrations of a skilled and knowledgeable consultant establishing complex relationships with several commanders and contributing to profound organizational improvements and changes. He also noted an example of a relatively uncomplicated consultation performed by a non-professional who may have had marginal familiarization with the principles and techniques of command consultation. This respondent felt that the essential variable was not the consultation function itself, but rather the special set of empirical circumstances associated with the task and by the practitioner's skill levels.

Some respondents expressed points of view that were more consistent with the raw numerical data which indicated that complexity was an issue of consequence in relation to the overall impact on command consultation's adoption. One subject blatantly stated that because command consultation was so complex, "advanced, formal education which focused specifically on consultation to organizations was a necessity." Another subject said this: "Too many practitioners took the matter entirely too lightly. Engaging commanders in the day to day business of their organization is a difficult task." This individual went on to say that practitioners need to acquire the skills necessary for performing as consultants. "Specifically, orientation sessions and/or elaborate in-service training programs are necessary."

Finally, this respondent identified the difficulty of engaging in command consultation with the highly ambiguous nature of the task and that the objectives were not well defined:

> I found that what I did had no sanction—no direction. I did what I instinctively felt I should. I was lucky in that it was successful. I found myself in a highly ambiguous role as a social worker and was uncomfortable. Fortunately, people found me useful but I had to give a hard sell approach. I felt then that it was extremely difficult and it would be until the Army regarded it as a clearly needed useful function, well documented and part of the regulation.

In the case of this respondent, it is noted that he engaged in command consultation despite his perception of it as an extremely difficult process. While it suggests that some

individuals may have chosen to engage in command consultation even though it was complex and difficult, the overall theme of the data indicates that respondent involvement was largely temporary or limited. The relative complexity of command consultation was a matter of significance and one that needed to be considered in spreading the practice throughout the system.

Compatibility with Practitioner Capabilities

Another item that the respondents were asked to evaluate in terms of the extent to which it interfered with command consultation's success was this: "Is it threatening to consult with higher ranking commanders?" Respondents ranked it seventh among the list of ten items, an indication that they did not regard this issue as a significant hinderance to command consultation activity. Fifty-seven percent of the respondents said it "never or only slightly interfered" while 43 percent noted that it "moderately or strongly interfered" with the development of command consultation. Commenting on this topic, a respondent had this to say:

> All social workers can do command consultation regardless of rank or the rank of the consultees. Can do and doing, however, are two different things altogether. To do command consultation, in my opinion, requires formal training . . . .

In a similar vein, another respondent had the following reply:

> I believe that one's level of practice and/or experience along with an understanding of the conceptual framework have more to do with sound command consultation than rank.

In another portion of the full scale survey, this same issue was raised in a different series of specific questions only dealing with rank differences and the effect on the consultation process. Within the context of these questions, the results differ with those cited above. Subjects were asked this question: "To what extent do you feel that 'rank differences' generally affect the consultation process?" (An example of a "rank difference" was given as follows: A social work captain consulting with a commander whose rank was major or lieutenant would be considered a "rank difference.") To this question, 72 percent responded that it had a "significant to moderate" effect while 22 percent said it had a "slight effect." Only 6 percent stated it had "no effect." The respondents who mentioned that they perceived some effect stemming from rank differences were then asked this follow-up question: "Do you think the effects are usually beneficial or detrimental to the consultation process?" to which 68 percent noted that the effects were detrimental and 32 percent said the effects were beneficial. On the basis of this finding, it is clear that rank differences alone were a distinct impediment to command consultation's progress. However, when perceived within the context of other issues, this impediment was comparatively small.

Observable Rewards

Respondents were asked to rank the degree to which they believed the "rewards of doing command consultation are readily observable." In relation to the overall list of ten items, respondents ranked this item eighth, with 65 percent noting that it either "never or only slightly interfered," and 35 percent saying it "moderately or strongly interfered." In the comments portion of the survey, respondents noted that the results of a consultation process are usually not "measurable or observable." As one member of the study sample put it, "objective criteria for evaluating results simply do not exist. While doing consultation usually feels good, it is pretty difficult to convince others about a feeling." Indeed, the issue of convincing higher echelon policy makers and decision makers about the proven statistical validity of command consultation was a great problem, as this subject expresses.

Elitism

During the pilot interviews, there was a suggestion by several individuals that engaging in consultation might have been an elitist practice and was therefore seen as objectionable. The question was put to the members of the full-scale study group which ranked this item ninth, in effect stating that it did not interfere with the growth of command consultation. Specifically, 86 percent indicated that it "never or only slightly interfered"; 10 percent noted that it "moderately

interfered," and just 4 percent believed it "strongly interfered." The idea of elitism was commented upon by several respondents. One subject stated that he often ". . . equate(d) command consultation practice with being a 'missionary,' a most uncomfortable role." To this he added, "one cannot help but visualize what it must have been like observing the MHCS staff emerging from the clinic, departing from traditionally perceived roles and embarking on a mission of teaching commanders something about their troops."

Another respondent stated that consultation in the field was potentially disasterous, particularly if the social worker submitted to rank conscious elitism and forgot about professional conpetence.

Still another subject said that "elitist qualities tend to adhere to the role of consultant; qualities which portray the social worker as an omnipotent, all knowing expert." This subject noted that client resentment toward the consultant, with subsequent rejection, is a frequent outcome and does not serve legitimate social work interests.

Although respondents ranked elitism ninth in a list of factors which inhibited the practice of command consultation, several respondents nevertheless voiced strong feelings about this issue; so its effect on the adoption of command consultation should be weighed accordingly.

Values

The item which ranked tenth and therefore interfered least with command consultation's successful adoption was the following: "Command consultation is not consistent with the traditions of social work practice." It is noted that this item is negatively phrased and was included with nine other items that were suggested to interfere with command consultation practice. Respondents were clearly not influenced by this negative phrasing, with 91 percent stating that either it "never interfered" or it only "interfered slightly." Just 9 percent felt it "moderately interfered." As expected, this item was felt by the respondents to least hinder successful development of the consultation movement.

In designing this study, it was believed that the question of how command consultation was valued by the target practitioners was critical to its successful introduction into the MHCS. Such individuals must perceive a greater value or benefit accruing to themselves or to the organization as a consequence of an innovation's introduction. In order to further test the validity of this issue of values compatibility between command consultation and social work, a similar question was put to the respondents in a separate portion of the full scale survey: "Is command consultation as you understand it consistent with existing values of social work?" With great consistency in the responses, 93 percent of the study sample expressed a point of view that

command consultation was compatible with existing values of social work; only 7 percent believed it to be inconsistent.

While highly congruent results were obtained regarding these reverse worded items dealing with values compatibility between command consultation and social work, some respondents expressed a feeling that it was the setting that was in conflict. For example, one respondent stated strongly that while command consultation was a valuable function, it existed within an authoritarian military setting where values basically violate those of social work and command consultation. He noted the following:

> I found the Army difficult to do command consultation largely because the system is based on non-humanistic values. What can a social worker do about that? I'm not sure I know! My personal experience was to invest energy in command consultation several times in my Army career, but to go back to my clients and my MHCS office when frustration built up once again.

In short, while questions were raised by respondents regarding the appropriateness of the setting, there was nearly unanimous agreement that the values inherent within the innovation of command consultation were consistent with social work practice.

Relative Advantage to Command Consultation Activity

The preceding discussion dealt with ten issues that were perceived by the study respondents to have interfered in varying degrees with the successful implementation of command consultation. The seven issues to be addressed in

the subsequent discussion were originally suggested by members of the pilot study as reasons considered of value in practicing command consultation. Full scale study respondents were therefore asked the extent to which they valued each of the following reasons for practicing command consultation. The responses and rank ordering of these items are presented in table 18.

The most heavily valued reason for engaging in command consultation was that the process "familiarizes commanders with new knowledge or different perceptions of a problem, and thereby enables them to more effectively help troubled soldiers." Ninety-two percent of the respondents indicated that they "highly valued" or "somewhat highly valued" this reason for engaging in command consultation. Ranked first among the other seven items, this reason for adopting consultation methods would seem to be very strong. Paradoxically, there is little discussion throughout the hundreds of respondents' comments that relate to this motive for operating in a consultation capacity. What this seems to suggest is that given a list of seven sound reasons for doing consultation, respondents selected as its highest ranking item a preventive concept which is aimed at the benefit of the consultee. However, when permitted the opportunity to freely comment and consider various implications of command consultation, few respondents identified this as a singularly important reason for valuing command consultation.

TABLE 18

ITEMS PERTAINING TO COMMAND CONSULTATION BELIEVED TO BE OF VALUE TO ITS SUCCESSFUL IMPLEMENTATION

Reasons Believed to be of Value for Practicing Command Consultation	(N)	Percentage of Respondents Who Value Reason Very Highly to Somewhat Highly	Percentage of Respondents Who Value Reason Moderately to Slightly
Familiarizes commanders with new knowledge or different perceptions of a problem and thereby enables them to more effectively help troubled soldiers	163	92%	8%
Maximizes effectiveness in the total organization	163	77	23
Best use of manpower and personnel	163	73	27
Prevents social dysfunction	163	67	33
Helps to break down stigma associated with mental health problems	163	65	35
Most efficient means of helping the individual	163	53	47
Cuts down on referrals to the Mental Hygiene Service	163	44	56

NOTE: The data represent adjusted percentage frequencies.

The four items which respondents ranked 2nd, 3rd, 4th, and 5th were rated to be relatively advantageous reasons for practicing command consultation. The percentage scores of the social work respondents who "highly" and "somewhat highly" valued these reasons for engaging in command consultation ranged from 77 percent to 65 percent. The subject areas of these rankings included "maximizing effectiveness in the total organization, best use of manpower, preventing social dysfunction, and breaking down stigma of mental health problems." Each of these items was indicative of organizational and systems enhancing reasons for practicing command consultation. As was expected, the respondents expressed this point of view with a substantial degree of consensus. One respondent made the following comment in relation to most of the items in this question:

> Most of what you have listed in this question as reasons for practicing command consultation are like ice cream, apple pie and baseball. Who could find fault with these as a rationale for doing command consultation?

Putting the issue in such terms does raise the further consideration that if these are such sound reasons for practicing command consultation, it is interesting that one-fourth to one-third of the respondents only valued these reasons moderately to slightly.

The item respondents ranked sixth was that command consultation was the "most efficient means of helping the individual." The reason was valued by 53 percent while 47 percent noted that they did not particularly value this as a

reason for practicing command consultation. It is clear that on the basis of the positions in which respondents ranked the previous items, organizational needs supersede the needs of the individual with regard to the rationale for practicing command consultation. These data also indicate that about half of the respondents do not perceive that command consultation is the most useful function for engaging the individual in a helping process. The implicit notion that respondents seem to be addressing is that if one is concerned about the needs of the individual, then an alternate practice function, i.e., something other than command consultation, should be used.

"Cutting down on referrals to the mental hygiene service" was the seventh and final ranked item in this question. It could be perceived that an item of this nature has an aura of self-interest and it would not be surprising that the respondents would choose to rank higher those items that have to do with the needs of the organization and individual. Nevertheless, this was a far from unanimous point of view because 44 percent of the respondents did value this as a reason for practicing command consultation.

Institutionalization

The previous section examined the actual experience that 163 social work practitioners had with command consultation. However, it is one thing for individuals to claim

that they practiced and supported command consultation and quite another in discovering the extent to which the innovation had actually been integrated within the broader context of the organization. This section will explore the degree to which the Army at large and, more specifically, the MHCS generated and maintained capabilities for creating an accepted and stable framework for the conduct of command consultation. Systematic procedures for insuring the success of the command consultation innovation are founded on such elements as policy, directives, literature, evaluation, professional meetings, educational programming, etc. The data collection process focused directly on these areas and this portion of the chapter will describe these study results, thus helping to account for the extent to which command consultation gained (or failed to gain) system wide support and acceptance.

Earlier, it was mentioned that a survey was necessary to provide a "general overview" of how this special audience of Army social workers perceived the developments of command consultation. In designing the survey, structured specific questions were developed. In addition, it was also felt important to provide the respondents with open-ended opportunities to freely comment in the survey on their own reactions to what had taken place. Thus, the survey produced data of a general nature and it allowed respondents the option to relate descriptions of their specific, unique empirical involvement with command consultation. In short,

two distinct forms of data results were gathered and may be characterized as general versus specific, each complementing the other. Both sets of findings are presented to provide a unified and complete understanding of command consultation events.

Policy

The degree to which policy is formulated vis-a-vis an innovation is an indicator reflecting the extent to which that innovation may have been institutionalized. Policy is defined as a set of rules which govern the course of action that is pursued in achieving a particular objective. For the purpose of this discussion, two kinds of policy will be discussed: the first will be what Herbert Simon refers to as the written, formal "authoritatively promulgated rules."[9] In the case of command consultation, these are illustrated by the official regulations, training manuals, circulars, etc. The second form of policy is the informal, professed positions of those individuals who are located in the higher echelons of power and authority in an organization. The people holding this position regarding command consultation are the consultants in the Surgeon General's Office in Washington, D.C.

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[9] Herbert A. Simon, Administrative Behavior (New York: The Macmillan Company, 1968), p. 59.

Official Directives

It was assumed in this study that the presence or absence of policy directives, training manuals, and regulations would be a means of gauging the extent to which command consultation had been institutionalized. The respondents were asked this question: "Are there specific Army regulations which provide an official mandate for the practice of command consultation?" Table 19 presents the results of this question.

TABLE 19

ARE THERE SPECIFIC ARMY REGULATIONS THAT PROVIDE A MANDATE FOR THE PRACTICE OF COMMAND CONSULTATION

Response Category	Frequency	Percentage
Yes	75	47%
No	10	6
Do not know	74	47
No response	4	*
TOTAL	163	100%

*Percentages are adjusted to account for ambiguous/missing responses.

Table 19 shows that 47 percent of the sample gave a definitive "yes" to this question, while just 6 percent stated there were not any specific Army regulations. On the basis of this response, it is tempting to conclude that there was indeed an official mandate for the practice of

command consultation. However, 45 percent of the sample or 74 respondents stated they "did not know if there were specific regulations sanctioning command consultation." Because the sample consisted of the most experienced and involved people in the command consultation movement, it was surprising to discover that this percentage of respondents was not informed. If nearly half of these individuals knew nothing about whether or not there were specific Army regulations governing the practice of command consultation, the question of the degree of accuracy of the 46 percent who claimed there were regulations was brought into question.

In the comment portion of the survey, one respondent stated that the Army Social Work Handbook gave clear sanctions governing the practice of consultation activity. This study participant noted that the mission of the consultation service, as defined in this handbook, was to ". . . aid command in the conservation and effective utilization of manpower," and to ". . . assist commanders in the control of environmental factors which affect mental health." He also cited two additional documents which he claimed officially legitimated consultation practice.[10]

In commenting, another respondent viewed the materials cited above quite differently saying that he thought the few paragraphs dealing with the issue of consultation were really

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[10]Department of the Army, Army Social Work, Technical Manual 8-241 (Washington, D.C.: Department of the Army, 1958); and Army Regulation 40-216,"Neuropsychiatry" (Washington, D.C.: Department of the Army, 1959); Army Social Work Handbook, TM 8-246 (Washington, D.C.: Department of the Army, 1962), p. 240.

"literary exercises" and were essentially not reflective of institutionalized support of consultation service. He further explained that the training manual which defined the mission of the consultation service was manifestly filled with 247 pages describing medical and psychiatric conditions, social and emotional aspects of illness, interviewing social histories, etc. This respondent rhetorically asked: "How much genuine support do you think that the writers of this document really gave to consultation when just three cursory pages were devoted to consultation?" Continuing, he said that in terms of the regulation, "all that it did was provide an official mandate and procedure for establishing the MHCS. It had little if anything to say about consultation practice."[11]

In this same vein, respondents were asked about the extent to which the training manuals explained command consultation practice. Table 20 shows the results.

The response pattern in Table 20 is very consistent with the question about the existence of specific Army regulations. Again, a substantial portion of the respondents indicated a lack of knowledge about what the training manuals said of command consultation. Of particular significance is that just four respondents cited that the training manuals largely defined and clarified the techniques and practice of command consultation.

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[11]The training manual referred to by this respondent is the previously cited Army Social Work Handbook. The "three cursory pages" to which the subject refers are pp. 241-243.

TABLE 20

EXTENT TO WHICH TRAINING MANUALS EXPLAIN COMMAND CONSULTATION PRACTICE

Response Category	Frequency	Adjusted Frequency Percentage
Training Manuals say nothing about command consultation	8	5%
Training Manuals briefly mention command consultation	38	24
Training Manuals explain the principles of command consultation	42	27
Training Manuals largely define and clarify the techniques and practices of command consultation	4	2
Don't know what the Training Manuals say about command consultation	65	41
No response	6	*
TOTAL	163	100%

*Percentages adjusted to account for missing/ ambiguous data.

The disparate notions that existed among the respondents regarding this aspect of command consultation's institutionalization is well substantiated in the literature. For example, the contrasting views put forth by the study respondents is further dramatized by Kisel:

> Implicit in these official directives is a legitimate basis for the practice of command consultation even though the term command consultation, a term of recent origin and usage is not found in them. It should further be noted that these official directives to be examined

> in this section do not sufficiently differentiate between command consultation activities and classical evaluation and treatment activities . . . .[12]

On the one hand, Kisel asserts that the directives establish a legitimate basis for the practice of command consultation, but also contends that there is inadequate differentiation between this new mode of activity and traditional forms of practice. Based on these contradictions, it is difficult to maintain that these official directives are indicative of meaningful institutionalized sanctions for the practice of command consultation.

Maillet, in a contrasting analysis of the same official directives, states that the MHCS is a primary ". . . instrumentality through which three helping professions . . . lend their expertise to community caretakers, especially commanders, through consultative service, in the interest of prevention . . . ."[13] Continuing, Maillet notes that ". . . this perception of MHCS role is clearly central to doctrine contained in official MHCS directives."[14] In comparison to the conclusions drawn from Kisel's interpretation of the directives, Maillet's discussion appears to favor the conclusion that the official directives were indicative of an institutionalized practice function.

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[12]Kisel, "Command Consultation," p. 28.

[13]Maillet, "Readiness of Troop Commanders," pp. 32-33.

[14]Ibid., p. 33.

The differences in view among the respondents in the survey and between the literary analysis of the two writers just mentioned raises questions about the way the official directives can be interpreted. These questions are of importance to this study because if the directives were not clearly understood, or if they were not taken seriously by practitioners, this may help to explain the sporadic nature of consultation activity today.

Policies and Practices of the SGO Consultants

During the pilot phase of this study, it was observed by all respondents that the psychiatric, psychological, and social work consultants in the Office of the Surgeon General (SGO) were in positions to influence the policy and implementation of command consultation. Yet the policies that the consultants actually formulated were subject to a wide range of interpretation. Several respondents clearly stated that they believed the consultants gave unmistakable sanction to the practice of consultation. Other respondents vociferously disagreed. Many of the consultants, the respondents wrote, contributed to the literature and occasionally paid visits to the MHCS advocating the adoption of command consultation practice. Some respondents stressed an absence of such activity. The respondents were asked to rate the impact that consultant policies had on the diffusion of command consultation practice. Forty percent responded that the consultants

did not write policy that was beneficial to spreading command consultation activity. Sixty percent believed that writing policy was "moderately or highly beneficial."

The single consultant activity believed by the respondents to have the most potential benefit was the assignment of specialized personnel to appropriate command consultation positions. This activity was indicated by 78 percent as "moderately or highly beneficial." Interestingly, several respondents chose to comment at greater length over the lack of congruency between what the consultants said regarding their support for command consultation and what they actually did to promulgate it. While several respondents stated that they were generally sure that the consultants adopted the principle of consultation practice, the actions of these consultants often led the respondents into believing that the consultant's "bona-fide supports lay elsewhere." As an example, one respondent noted that if the consultant in Washington were really committed to developing well integrated consultation programs, ". . . don't you think care would have been taken in making appropriate assignment matches?" Continuing, the respondent made the following comment:

> Where do you think Colonel _____'s sentiments were when he took one of his best social work officers out of an established consultation service at Fort _____, and sent him overseas to do family therapy. Well, he was replaced with an inexperienced individual right out of graduate school, and in just eight months, there was no trace of the original field consultation program.

Another respondent pointed out that the author of one of the survey questions assumed, perhaps falsely, that the consultants in the Office of the Surgeon General were conducting a variety of activities in helping to spread the idea and encourage the practice of command consultation:

> I disagree with your premise in item #58 that the consultants were doing these things. I have not observed too much of this kind of activity that you suggest occurred.

This respondent's point of view was supported by Monahan, a former social service consultant:

> From personal experience, I have often wondered if the Mental Hygiene Consultation Service program was, in fact, being carried out as we envision it at this level. It seems that empirical research would enable us to gain proper perspective of how our Mental Hygiene Consultation Service programs are being implemented.[15]

When asked to rate the value of the SGO Consultants supporting and encouraging research, 50 percent of the respondents were not quite as enthusiastic as the individual quoted above. These respondents noted that the SGO consultant's support of research was "not beneficial or just slightly beneficial." The remaining 50 percent of the sample answered that research support was "moderately or highly beneficial."

Pragmatic Policy Communicated to Recipients of Service

In order for a program to be understood, adopted, and spread throughout the system, information about it must be communicated. An important element for institutionalizing

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[15]From a letter by Lt. Colonel Fergus Monahan, 9 March 1966. See Maillet, "Readiness of Troop Commanders," p. 34.

command consultation is the means by which prospective recipients of service become familiar with its procedures and knowledgeable about its availability. Respondents were explicitly asked if they believed that knowledge about the availability of command consultation services had been effectively communicated to recipients of MHCS services, namely, consultees. Negatively responding to this question were 80 percent of the sample; 20 percent thought recipients received effective communication regarding availability of services. More detailed information was sought from the respondents regarding specific ways in which they believed commanders actually learned about command consultation and ways in which commanders should have learned about command consultation. The reader is referred to table 17 earlier in this chapter where a more thorough discussion of this issue was presented.

The comments of most respondents suggested that the primary means by which commanders learned about the availability of consultation services was through the informal networks of each local MHCS. The most frequent response was that if the MHCS had a command consultation capability, "word about it got around." Few subjects were aware of any formal Department of Army regulation which gave guidance or direction to individual commanders in familiarizing them with what was expected to be a consultation capability in the local MHCS. Some respondents commented that in effective consultation programs, an energetic social worker or psychiatrist

would individually need to convince the post commander on the value of the program and then have him put out local circulars to provide necessary information. In short, the information network for guaranteeing Army wide knowledge about commmand consultation capability was largely left to chance with heavy reliance on the sales expertise and motivation of MHCS personnel and on the mental health philosophy and willingness of the post or hospital commander. Except for training manuals and the single Army regulation, all of which were directed to mental health personnel, no official Department of the Army regulations provided guidance to the intended recipients of service. What seems apparent is that command consultation was never institutionalized with regard to well established policy, but remained in its social movement stage of a basically informal, unorganized, and uncoordinated life cycle.[16]

Literature

If an innovation becomes well integrated into the existing social system, it is expected that literature will evolve to describe and conceptualize the new idea. What may be the most complete historical volume in military social work literature is Ralph Morgan's work which identified social work accomplishments, organization, and philosophy

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[16] See Mauss, Social Problems.

during the period 1947 through 1959. It is noteworthy that Morgan's literary investigation makes no reference whatever to the Army's command consultation program. Going on the assumption that a command consultation program falls most closely within the community organization component of social work practice, this is what Morgan had to say about the subject:

> . . . it must be said that Army social work has not moved aggressively into community organization during its existence. In view of the fact that Army social work has always been clinical in character and that its professional efforts must be related rationally to the function of the Army Medical Service, then the accomplishments of Army social workers in community organization appear to be of more value and significance than if considered out of such context.[17]

The question of this void suggests that during this time period command consultation was not recognized in the formal literature of social work to be a major movement.

In commenting on the content and impact of the literature, respondents noted differences regarding the degree to which they believed that this affected the spread of command consultation. One of the sharpest criticisms was that the published material was all "one sided." The respondent who made this observation stated that he had never seen or heard about an article or paper which presented both the pros and cons of command consultation. He said that the primary

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[17] Ralph W. Morgan, Clinical Social Work in the U.S. Army, 1947-1959 (D.S.W. dissertation published by The Catholic University of America, Washington, D.C., 1961), p. 334.

thrust in the literature was that command consultation was a heavily favored approach, and everything he had seen and read on the subject reflected that singular view.

Another respondent thought that the literature on command consultation failed to encompass other fields in which consultation activity had been more systematically formulated. He said that except for a few isolated instances of drawing on Caplan's work in community psychiatry and Rapoport's writing in social work, the command consultation conceptualization was "narrowly confined."

Another individual in the pilot interviews thought that the contribution to the literature was one of the more "remarkable" aspects of the program. This respondent stated that in terms of the small numbers of individuals who were involved in the activity, a great proportion of these persons had written formal and informal descriptions of their work in the MHCS and in field consultation programs in particular. He noted that this reflected wide acceptance of command consultation and a strong desire to spread knowledge about it.

Respondents were specifically asked in the full scale survey to identify what they believed to be the nature of the published literature on command consultation. Sixty-two percent indicated that there was either "a minimal amount of material written on the subject, virtually nothing written on command consultation, or did not know what had been written"; 29 percent replied that there was an "average" selection of

writing on command consultation, and just 9 percent thought that the published literature was "substantial." When further asked about the impact that the published literature had in determining the extent to which they actually learned about command consultation, 53 percent stated that it had either "no impact" or "slight impact." Those noting that the literature had a moderate impact on how they learned about command consultation were 34 percent, while just 13 percent stated it had a "strong impact."

The extent to which respondents in the full scale survey had written on the topic of command consultation was also considered to be a relevant area of inquiry in determining how thoroughly command consultation was institutionalized. The following statement was put to the sample: "Indicate the number of papers or articles you wrote which were specifically about command consultation," to which 70 percent stated that they had written nothing on this subject; 15 percent noted that they had written one article, and 15 percent replied that they had written two or more articles on command consultation.

The significance of the data and contrasting comments is that well over half of the study sample (1) perceived the literature on command consultation to be virtually nonexistent, (2) did not know what had been written, and (3) received minimal benefit in terms of the literature contributing to their learning about command consultation.

Although 30 percent of the respondents wrote about command consultation, another 70 percent remained uninformed about this material. It is re-emphasized that the study sample consisted of selected Army social workers who were specifically screened in terms of being practitioners most familiar with and knowledgeable about command consultation. Moreover, the academic credentials of this group are also exceedingly high with 13 percent possessing doctoral degrees, 29 percent having some post master's work, and 38 percent having master's degrees. If this group's knowledge and use of the literature were so marginal, it is probable that the masses of other social work practitioners had substantially less familiarity. Therefore, there is serious question over how extensively command consultation could have become integrated into the Army's MHCS if the member practitioners and founders were as minimally familiar with the literature as indicated by these data.

Training and Education

If a social change has become institutionalized, it is assumed that provisions are made for teaching individuals about the new idea. Extensive discussion was presented in chapter four at the section entitled "Learning and Knowledge." The issues of how social work practitioners learned about command consultation and the degree to which they were prepared were a major focus of that discourse. The emphasis of the discussion was that the data indicated a profound absence

of formal orientation programs for providing incoming social work personnel with knowledge pertinent to command consultation practice. One individual made this comment:

> At one point in my career, I had never had an experience in the MHCS or with command consultation. When I was eventually assigned to a facility that did command consultation, I had to pick it up as I went along.

Another respondent puzzled over why command consultation had never been taught during a social worker's orientation into the Army.[18] He wrote that the existing orientation programs taught to new social workers pertained primarily to matters concerning military structure and function.[19] Commenting in greater detail, this respondent suggested that a social worker's professional graduate training was assumed to have a generic quality which provided him with all of the necessary skills and training he required.[20] Therefore, it was believed that once a new social worker got to his job, he would become familiar with command consultation through experience and exposure.

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[18]A two-month orientation called the Officer's Basic Course is provided to all incoming social work officers at the Academy of Health Sciences, formerly known as the Medical Field Service School.

[19]In figure 1 (page 107), respondents ranked "formal orientation courses upon entry into the Army social work program" last in a list of 15 ways in which social workers learned about command consultation.

[20]Glasscote and Gudeman note that such assumptions are not warranted because few professionals in community mental health are specifically trained for their jobs. Quoted in Lawrence Berg, William J. Reind, and Stephen Z. Cohen, "Social Workers in Community Mental Health" (The University of Chicago School of Social Service Administration, July 1972), p. 6.

Another respondent felt that because formal training was absent, an informal mechanism became the primary means by which professionals learned about command consultation. He called this the "mentor role," and described a process by which "more experienced professional personnel informally took a younger, inexperienced individual under his wing and familiarized him with the subtleties and techniques of command consultation." He noted that this was common and that most social workers probably acquired substantial knowledge of consultation in this manner.

Several respondents felt that significant education took place at professional meetings where papers were delivered on command consultation and where workshops were held. Another subject's feeling about this arrangement was that those who attended the conferences had the opportunity to learn about consultation, but those who did not attend lost out. (See section on professional meetings, page 183.)

One individual in the survey thought that if an individual were interested in consultation practice, there was an abundance of published papers on the subject from which he could obtain knowledge. Several respondents felt that while the literature on the subject of command consultation was growing and represented a valued resource, it wasn't realistic to expect that the majority of practitioners would gain a "working knowledge" of consultation merely from reading and studying.

In-service training at the local level was regarded by many respondents as the primary means by which practitioners in the MHCS learned about command consultation.[21] Many MHCS programs relied on their own experienced personnel to teach while other MHCS programs depended on the expertise of paid consultants. There was mixed sentiment regarding the effectiveness of this means of staff training. While some believed it had value at the local level, others criticized it because it lacked the consistency of a systematized institutionalized training program. As one individual stated: "In some well established MHCS programs, it worked well; in other places, it was a flop."

Professional Meetings

An indicator of the degree to which an innovation becomes integrated within a system has to do with the readiness of its members to discuss it at professional meetings and conferences. Table 21 shows what emphasis command consultation topics were given at Army social work conferences or at multi-disciplined professional meetings.

The respondents clearly indicate that in terms of strong emphasis, command consultation achieved its peak in the early 1960s and then tapered off through the latter half of the sixties and early seventies.

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[21] An illustration of one staff development program, which was presented in 1969 at Fort Dix, is located in Appendix F.

TABLE 21

EMPHASIS GIVEN TO COMMAND CONSULTATION AT PROFESSIONAL MEETINGS AND CONFERENCES DURING SELECTED HISTORICAL TIME PERIODS

	(N)	Strong Emphasis	Moderate Emphasis	Weak Emphasis	No Emphasis
Early 1950s	57	12%	21%	49%	18%
Late 1950s	67	28	39	31	2
Early 1960s	91	52	39	10	1
Late 1960s	134	26	48	22	4
Early 1970s	82	15	49	28	9

NOTE: Data in the above table represent percentages on actual number of respondents reporting applicable Army social work experience during each respective time period.

It was found from the comments of the respondents that command consultation had been a frequent topic at professional gatherings of Army social workers, psychiatrists, and psychologists. Issues relevant to both practice and theory had been dealt with in workshops and seminars. Major papers had been delivered with command consultation often the primary theme. Several respondents commented that the regularity with which command consultation had been dealt at professional meetings was an indication of the extent to which further development of the idea was sought by its promulgators. Another subject felt that the repetitive discussions of the same problems which afflict field consultation activity does not reflect its institutionalization but rather its "pathological symptoms."

At the 1974 Current Trends Course in Army Social Work, the discussion leader summarized an afternoon workshop with the following statement: "We have been discussing these issues about the Mental Hygiene Consultation Service for five, ten, and fifteen years now, and it seems to me that we are saying the same things now that we were saying then." Thus, one perception of this phenomena may be that conference themes are an indication of the organization's sanctions for command consultation, whereas the repetitious nature of the discussion may reflect the lack of uniform development and acceptance.

Verification and Evaluation

If an innovation has been institutionalized, it may be expected that a corresponding means for validation should exist. The survey showed a marked absence of any research system which would verify that personnel in the MHCS were actually performing command consultation. Some respondents felt that it should have been the job of the social work consultant in the Surgeon General's Office to put out clear directives and insist on accurate reports of the activities in each of the MHCS programs. While each MHCS was expected to maintain monthly statistical records and annual reports of the activity performed, several respondents reported that these reports are "inaccurate, inflated and inconsistent."[22]

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[22]It is noted that when the investigator visited Ft. Detrick, Md., in the spring months of 1975 to review archival collections of MHCS activity, a relatively meager amount of

One respondent stated that

> If you want a program to run efficiently, you don't leave it to everyone's individual discretion to do what he feels is best. There is a need for guidelines and organization. There must be verification, and I didn't see too much of this with the command consultation idea.

Evaluation of the command consultation program has been debated since the program's inception over three decades ago. There is little research to show that positive outcomes can be directly attributable to a command consultation mode of operation. Holloway has stated that ". . . there has not been an operational formulation of this (command consultation) as a series of actions within which empirical measurements can demonstrate whether it works or does not work."[23] Respondents in the full scale survey commented about this matter with statements such as the following:

> Don't ask me to prove that command consultation works. I do it because I have faith in it and for me, that's sufficient reason.

> I knew when I had had a success when I consulted with commanders. It felt mighty damn good. Now if we had the numbers to show that it was successful, that would be an accomplishment.

Some studies conducted on command consultation operations claim that the process produces demonstrable improvements in AWOL rates, sick call reductions, etc. For example, Baxter reported on the results of a consultative

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information was available on the subject of command consultation. The annual reports submitted by hospitals throughout the U.S. Army were carefully scrutinized and in all, just four formal reports were on hand which related to command consultation content.

[23]Holloway, interview.

effort to evaluate a stockade program and to make recommendations about reducing the prisoner population. After a program consultant spent several weeks consulting with stockade personnel and other staff agencies having a direct relation to stockade prisoners, the following result occurred:

> Suffice it to say that the stockade input rate dropped from 5/day average for 365 days/year in 1962, to 3/day for 1963. The last six months, it has dropped to 1.7. The population confinement ratio went from 8/1000 in February, 1963 to 2.9/1000 in December, 1963. And we can do better![24]

This report by Baxter represented one effort to show that preventively oriented practice by mental health personnel could produce measurable outcomes. Interestingly, Baxter was one of few individuals who was aware of the connection between (1) evaluating "cost benefits" that accrue to an organization when it adopts a new idea, and (2) the eventual systemic institutionalization of the new mode of practice—in this case, command consultation. Unfortunately for command consultation, few other social workers had the foresight or interest in evaluating or documenting command consultation results. Under such circumstances, the chances for this innovation to become institutionalized decrease markedly.

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[24]Roy E. Baxter, "The Creation and Development of a Command Consultation Service Program: Chippers of Stone and Something More, 1962-1964," proceedings from the 14th Annual US Army Clinical Social Work Conference, Los Angeles, Ca., May 23-26, 1964, pp. 35-36.

Command Consultation and Status of the Profession

The preceding section focused on the degree with which the innovation called command consultation was integrated into the Army's Mental Hygiene Consultation Service. It described how a variety of forces combined to influence the degree to which a new idea or program becomes established and institutionalized. Another factor that has to do with the diffusion of an innovation is the existing condition of an institution or organization that lends favor (or disfavor, as the case may be) to the introduction of a new idea. In the case of command consultation, the professional status of Army social work was a condition that influenced how this innovation was accepted/rejected. A premise of this study is that social work in both the military and civilian community has long struggled with its professional identity.

The first part of this section will detail this identity issue and will explore the extent to which respondents in this study perceived Army social work as a "marginal profession." It will present the findings and analyze whether or not this concept of marginality may have led Army social workers to a search for recognition and acceptance. The vehicle through which Army social work had the opportunity to attain this goal was command consultation. During the earliest phase of the pilot interviews, respondents almost unanimously asserted that the developing practice of command consultation was linked to the professionalization of social

work in the Army. Basically, two distinctly different connections were observed in the pilot interviews and each seemed to derive from dramatically dichotomous positions. These will be discussed in the second part of this chapter as intrinsic and extrinsic motivations that spurred Army social work in its search for professional status.

Army Social Work Status in an Historical Perspective

An assumption of this study generated out of the early pilot interviews was that the innovation of command consultation had strong appeal to Army social workers, particularly because this new movement held the potential value of enabling social workers to achieve greater recognition for their profession. The subject of social work's standing has been an issue for social work in general since Abraham Flexner concluded in 1915 that the field of social work lacked the criteria necessary to be included within the ranks of a "profession."[25] Others have researched this matter in attempts to define the characteristics of social work and to establish a basis by which social work could legitimately be classified as a profession.[26] Paul Weinberger, social work

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[25]Flexner, "Is Social Work a Profession?"

[26]For an historical and contemporary overview of this process, see "Profession of Social Work: Code of Ethics," p. 958; "Profession of Social Work: Contemporary Characteristics," p. 959; "Professions, Human Service," pp. 982, 989, in Encyclopedia of Social Work (New York: National Association of Social Workers, 1971).

academician, discusses the ". . . low opinion of social workers held in the past by the general public . . . ," and he casts this problem within the framework of professional status and the corresponding effects on self-concept, relationships with clients and associates, and feelings about one's job.[27]

The subject of Army social workers' role and status was described by Krise twenty years ago:

> It has been a common experience that . . . we are commonly identified as "psychiatrists," or, even more frequently, "psychologists." The inference is, or course, that the term "social worker" is, in the minds of the general public, a low status term and people with whom we deal cannot associate this term with persons who enjoy high status because of association and identification with the psychological disciplines.
>
> Consequently, my primary thesis . . . is that social work is a "marginal profession."[28]

The issue of whether or not social work is, or has been, a "marginal profession" is really not the subject of this report. The extent, however, to which its own members thought this to be true is an important factor which is believed to have affected the diffusion of command consultation. In order to assess this issue, a series of questions was posed to the respondents—questions dealing with the status of Army social work and the resultant relationship with the development of command consultation.

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[27]Paul E. Weinberger, "The Objective Professional Status of Social Workers," Personnel Information 12 (July 1969): 3.

[28]Edward F. Krise, "The Challenge for Social Work Leadership," Ninth Annual Army Social Work Conference—Planning for Professional Leadership, Letterman Army Hospital, San Francisco, May 23-24, 1959.

When questions of professional status are raised, it is implicit that one thing is being compared with another. For social work, the points of comparison are the professions of psychology and psychiatry, and this was succinctly described by Krise.[29] Because social work has traditionally been subordinate to psychiatry, it was decided that respondents in the survey would be asked to consider what levels of professional status they thought Army social work had achieved in relation to psychiatry. Figure 3 presents the findings through the historical period covering the 1950s, 1960s, and early 1970s.

The findings clearly establish the differentiation in perceived professional status between social work and psychiatry from the early 1950s through the early 1970s. Ninety percent of the respondents indicate that in the early 1950s social work had lower status compared to psychiatry. During subsequent years, the percentage of respondents who perceived social work status to be lower than psychiatry declined. In the 1960s the percentage of respondents seeing lower status for social work was 67 percent. By 1970 the percentage had changed to the point where 48 percent believed social work's position was lower than psychiatry.

The graph also shows the percentages of respondents who perceived social work's status to be equal to that of

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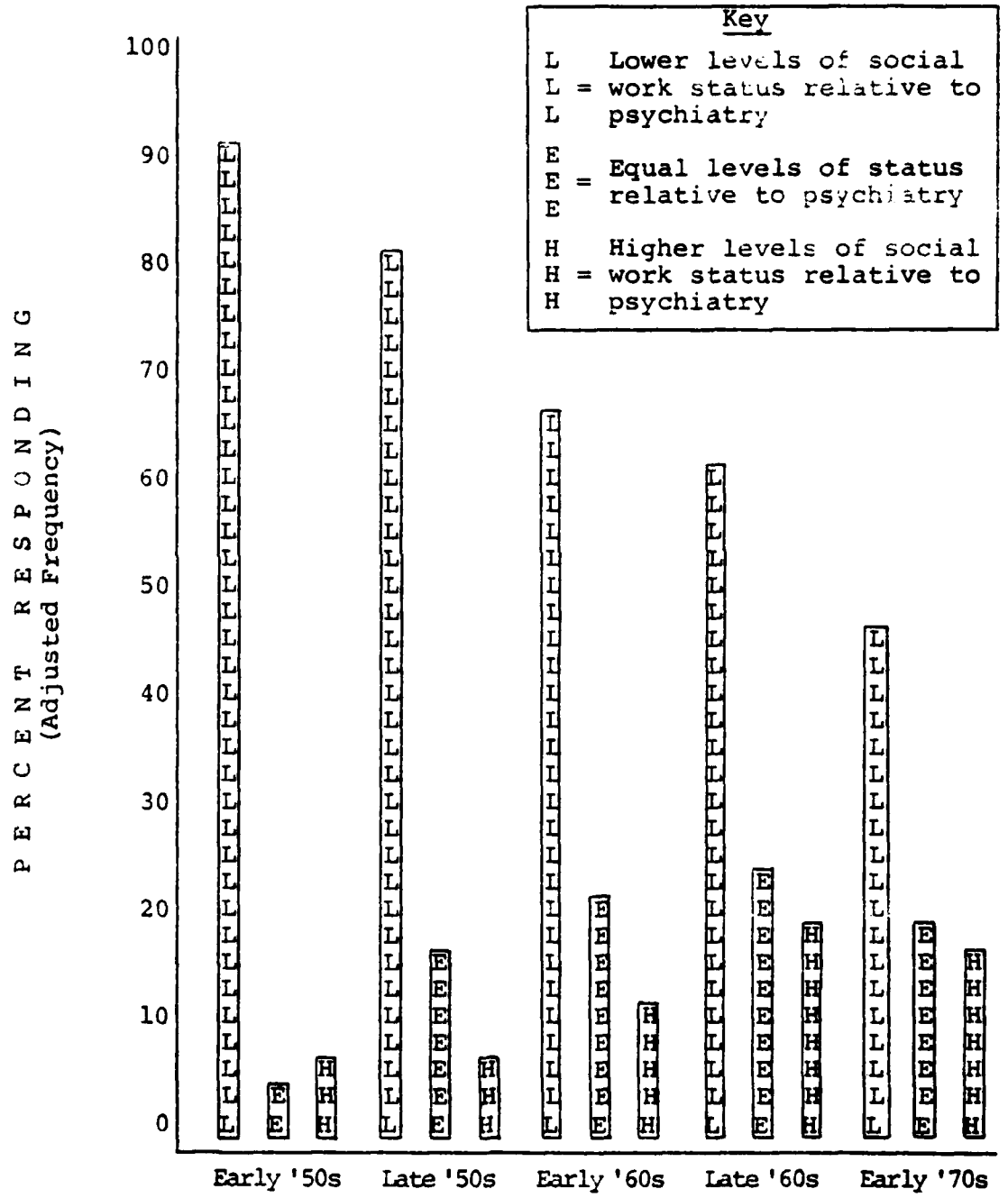
[29] Ibid.

FIGURE 3

RESPONDENTS' PERCEPTION OF THE STATUS BETWEEN SOCIAL WORK AND PSYCHIATRY DURING SELECTED HISTORICAL TIME PERIODS

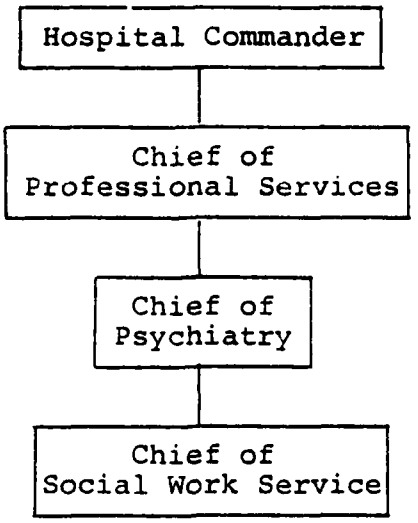


psychiatry. While only 4 percent of the respondents thought the levels of status to be equal in the 1950s, the figure had risen to 27 percent by 1970. While the findings show a steady rise among respondents who perceive social work with higher levels of status and a steady decline of social workers who view social work as having lower levels of status compared to psychiatry, there is nevertheless a large gap indicating quite vividly that there is little doubt about the fact that psychiatry has historically enjoyed, and continues to hold, significantly higher levels of status than social work. As one of the respondents put it: "Social work's lower status is a sociological and administrative fact where the social worker and psychiatrist work together." Or, as still another respondent commented: "The nature of the organization gives priority to the medical profession. Army social work in the MHCS has no status in the regulations—only in the minds of those who delude themselves with perceptions of status!"

Along with understanding respondents' perception of social work's status in relation to that of psychiatry, it was also essential to assess how the respondents viewed themselves in terms of being administratively and professionally subordinate to psychiatry during these same time periods. Social work has maintained dual roles in its relationship with psychiatry. Until the late 1960s, social work was administratively responsible to psychiatry in the formal chain of command, as figure 4 displays.

FIGURE 4

SOCIAL WORK'S RELATIONSHIP WITH PSYCHIATRY PRIOR TO 1967

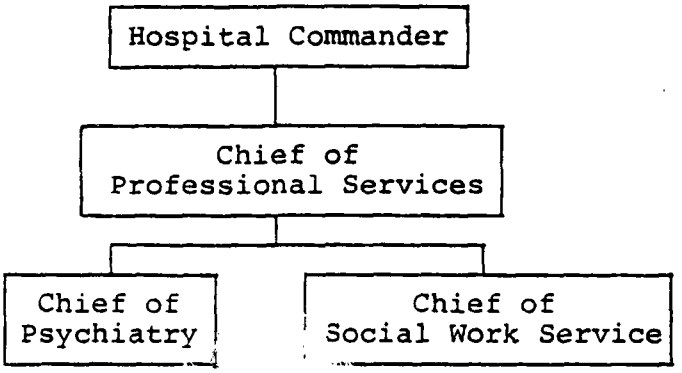


Psychiatrists evaluated social workers, approved their leave, designated their assignments, etc. This administrative aspect of the relationship existed as a matter of policy until 1967, when official Army regulations established social work as an administratively separate service in major Army medical centers. This meant that social work was no longer administratively linked to psychiatry in the official chain of command. Instead, social work became answerable directly to the chief of professional services rather than to the chief of psychiatry. Figure 5 portrays this change.

Along with administrative responsibility, social workers held another relationship with psychiatry, that is, a professional relationship. While the administrative role was

FIGURE 5

SOCIAL WORK'S RELATIONSHIP WITH PSYCHIATRY AFTER 1967



defined by policy and regulation, the professional role was individually and uniquely experienced by each social worker. This relationship was characterized by how the individual social worker perceived himself in relation to his professional knowledge and experience. Some social workers regarded themselves as being autonomous professionally even though administratively reliant on psychiatry. Such social workers worked with a psychological independence knowing that their body of social work knowledge clearly differentiated them from psychiatry. On the other hand, other social workers perceived their body of knowledge as being an off-shoot of psychiatry with attendant reliance on their "parent discipline" for professional guidance and supervision. This relationship was profoundly characterized by a respondent in the pilot survey who perceived his role as a "junior

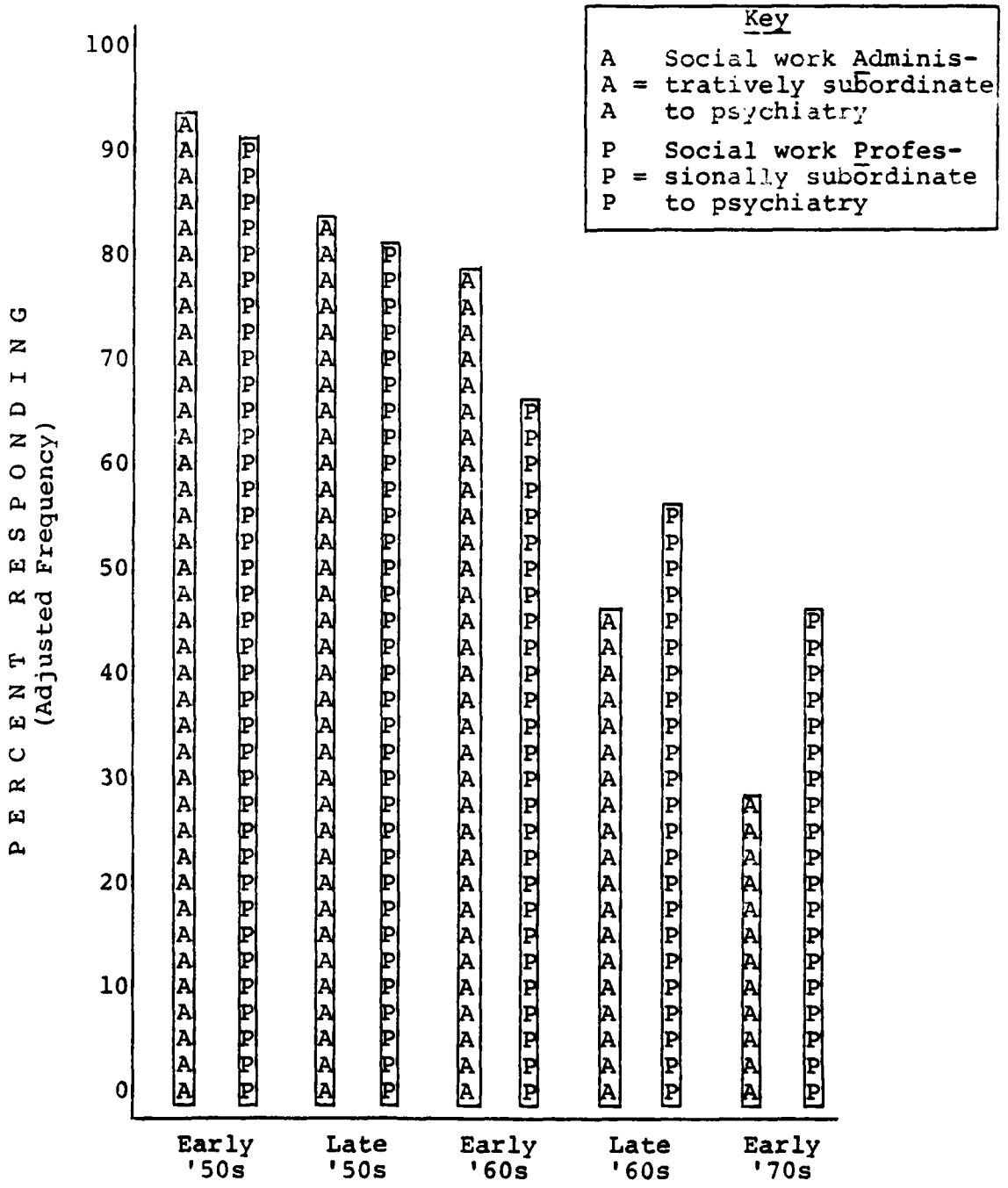
psychiatrist." Figure 6 identifies the historical pattern of how social workers perceived the condition of administrative versus professional subordination to psychiatry.

The findings depicted by this figure show that social work respondents perceived themselves to be administratively and professionally subordinate to psychiatry from the early 1950s through the early 1970s. In terms of administrative subordination, the findings showed a movement from 90 percent of the respondents viewing themselves as subordinate in the early 1950s to just 28 percent in the early 1970s. The extent to which respondents perceived a change in professional subordination was not so great, though a continuous decline was also revealed. This was evidenced by a shift from 88 percent of the respondents seeing themselves as professionally subordinate in the early 1950s to 44 percent in the early seventies. From the fifties through the early sixties, the number of social workers who saw themselves as administratively subordinate was always greater than the number of social workers who saw themselves as being professionally subordinate.

A reversal in this trend occurred in the 1960s when the number of social workers who viewed themselves as administratively subordinate dropped below the number of social workers perceiving themselves as professionally subordinate to psychiatry. The cause for this reversal is believed to have resulted directly from the fact that social work was

FIGURE 6

RESPONDENTS' PERCEPTION OF THE ADMINISTRATIVE AND PROFESSIONAL SUBORDINATION OF SOCIAL WORK TO PSYCHIATRY DURING SELECTED HISTORICAL TIME PERIODS



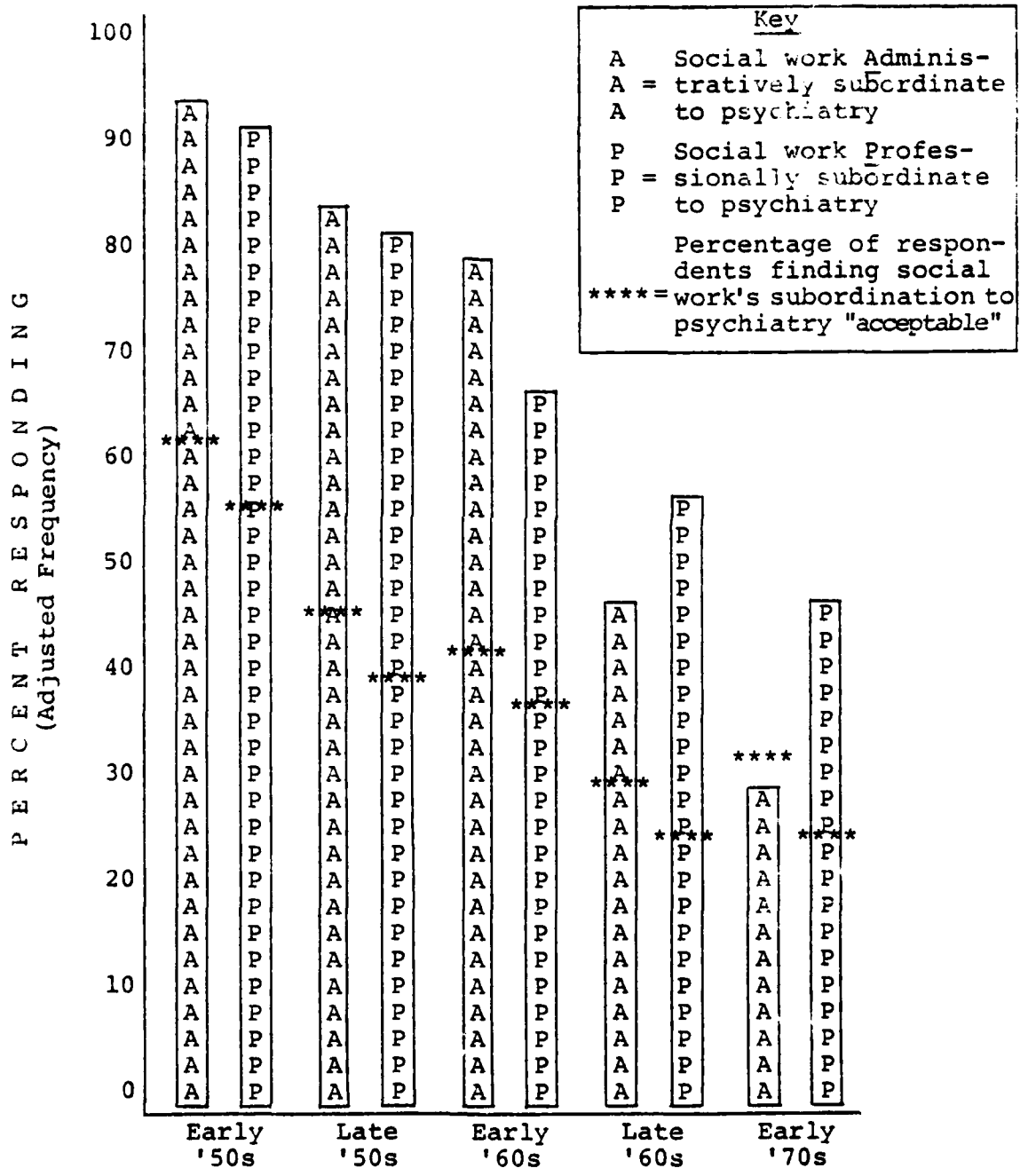
officially declared administratively separate from psychiatry.

Social work's subordination to psychiatry in and of itself is not especially profound. The concern, however, is whether or not this condition influenced the extent to which the innovation, command consultation, diffused throughout the mental hygiene consultation movement. Therefore, it was important to determine whether or not social workers found the existing subordination of social work to psychiatry acceptable or unacceptable, and figure 7 identifies how the respondents viewed this situation.

Figure 7 shows that in the early 1950s, 62 percent of the respondents believed it was acceptable for social work to be administratively subordinate to psychiatry. A slightly smaller percentage, 55 percent, thought it was acceptable for social work to be professionally subordinate to psychiatry. What is interesting is that over half of the participants thought it was acceptable that social work was administratively and professionally subordinate to psychiatry. Figure 7 reveals that during the years that followed, increasingly greater disaffection followed to the point where approximately 30 percent of the respondents thought it was acceptable that social work was administratively or professionally subordinate to psychiatry. Commenting, one of the respondents placed this pattern of the early acceptance of social work's subordination to psychiatry into historical perspective:

FIGURE 7

RESPONDENTS' PERCEPTION OF THE ACCEPTABILITY OF THE ADMINISTRATIVE AND PROFESSIONAL SUBORDINATION OF SOCIAL WORK TO PSYCHIATRY DURING SELECTED HISTORICAL TIME PERIODS



> In view of the times, it was premature to think differently. Looking at it realistically, it is like coming of age, that is, going from being subordinate to independent.

In further accounting for the substantially greater acceptance of psychiatry's control over social work, another respondent put it very aptly: "Social work would never have gotten in the front door if it were not for psychiatry." Nevertheless, it is within the context of these historical conditions that the impetus was established for social work's early identification with the command consultation movement.

Given social work's status and its subordination to psychiatry, the respondents were asked to identify the impact they thought the development of command consultation activity had on the professional status of Army social work. Table 22 presents how the respondents viewed this impact through the time frame of the fifties, sixties, and early seventies.

The findings in table 22 show that in the early 1950s when the practice of command consultation was relatively new, 47 percent of the respondents seemed to think that command consultation enhanced Army social work's status. In the late fifties and early sixties, 68 percent and ultimately nearly four-fifths of the respondents believed that the practice of command consultation enhanced Army social work's status. Curiously, a slight reversal in this trend occurred in the late 1960s and continued into the early 1970s where finally 68 percent of the respondents thought Army social work's status was enhanced. It should again be noted that at the

TABLE 22

IMPACT OF COMMAND CONSULTATION ON PROFESSIONAL STATUS OF ARMY SOCIAL WORK DURING SELECTED HISTORICAL TIME PERIODS

	(N)	Status Enhanced	Status Unaffected	Status Diminished
Early 1950s	57	47%	47%	5%
Late 1950s	69	68	29	3
Early 1960s	89	79	20	1
Late 1960s	150	74	2	5
Early 1970s	87	68	31	1

NOTE: Data in the above table represent percentages based on actual number of respondents reporting applicable Army social work experience during each respective time period.

time this reversal occurred, official Army medical department policy had established social work as a separate service. The data suggest that once social work had established itself independently from psychiatry in the late 1960s, command consultation might not have been needed any longer to fulfill this status-enhancing function. These data also correspond with figure 2 which shows that the overall development of command consultation reached its peak of understanding, practice and success in the early 1960s and then began to taper off through the early 1970s.

Intrinsic and Extrinsic Motivation

The previous portion of this chapter described the perceptions of status that social workers historically held relative to their own profession. Forces were gathering through the fifties and sixties which would provide a new direction for the profession. Command consultation served as a new vehicle for professional independence. Some social workers regarded command consultation to be a natural, spontaneous outgrowth of their work while others viewed it as a way of going beyond traditional practices of the profession in order to produce increased autonomy and prestige. These differing approaches will be examined in this section of the chapter as intrinsic and extrinsic motivational forces influencing the diffusion of command consultation.

"Intrinsic Motivation" is a concept derived from psychology and learning theory. It is defined as a course of behavior which is instigated by inherently natural needs and directed toward desirable goals.[30] In the present case, adoption of command consultation as a practice function in the mental hygiene consultation service is viewed as natural for social work. Perceived as a substantive part of the profession, command consultation was viewed by some social workers as a logical method for providing service to clients.

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[30]Ernest R. Hilgard, Introduction to Psychology (New York: Harcourt, Brace & Co., 1957), p. 269.

Respondents in the survey made reference to this "intrinsic" element of command consultation as a primary motivational force behind the early adoption and diffusion of this innovative practice function. These individuals felt that because Army social workers were engaging in a sound professional activity, increased recognition for the profession was a logical, natural consequence of this participation. There were no consciously planned efforts to establish gains for the profession and those that occurred were seen as spontaneous, unanticipated consequences resulting from the inherent value of the command consultation function itself. Thus, by virtue of Army social work's responsiveness in testing out and conceptualizing command consultation as a new aspect of practice, substantial movement was made toward enhanced professionalization.

Demonstrating new areas of expertise and practice skills further contributed to the notion that social work was adept in taking on a wide range of new professional tasks. This was aptly illustrated in the late sixties when Army social work became invested with a wide range of new staff, research, and academic positions of responsibility. Thus, readiness to adopt command consultation represented responsiveness to change and innovation, and by the very fact of its early success, this responsiveness was seen to correspond with increased prominence and recognition for Army social work.

A differing view of the motivational forces which promoted the diffusion of command consultation was suggested by other respondents in the survey. In contrast to the intrinsic nature of one set of forces driving command consultation's growth, an extrinsic motivational force was also identified. This concept is defined as a course of behavior prompted by disquieting pressures or uncomfortable events, and which is directed to desirable goals.[31]

As previously explained in the earlier section of this chapter, there was a general sense among these individuals that social work had long been misunderstood as a profession and had traditionally been a societal target of derision. In the survey, a respondent used the expression "junior psychiatrist" in a derogatory fashion referring to social work's low position relative to psychiatry. He commented as follows: "In my experience, line command and staff perceive social workers as psychiatrists and will refer to them as such."

The overall sample was asked if they had ever been called "junior psychiatrist" and 109 respondents (67 percent) reported that at some time in their professional career, they had been referred to in this manner. When asked how they reacted to this expression, 76 percent noted that they felt it to be an unacceptable term. One respondent commented that he felt a need to exhort his newer social workers to avoid

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[31]Cf. with definition of intrinsic motivation, ibid., p. 270.

becoming "junior shrinks." However, another respondent who took no offense toward this expression had this to say:

> Generally, when the term junior psychiatrist was used, you could use it to good advantage in developing a relationship. Too many social workers were fragile on this score. After all, a "rose is a rose, is a rose!"

The overriding theme presented by the majority of respondents was that, in general, Army social workers retained the same low standing as their civilian colleagues. One respondent elaborated on the idea that social work was established solely to carry out "messenger and secretarial" duties for psychiatry. Another individual was especially bitter over what he perceived to be the overall relationship between social work and psychiatry. His caustic remark that "social work had been psychiatry's nigger long enough" succinctly characterized his perceptions of social work's position. He thought that it was perfectly logical to conclude that command consultation offered social work an excellent opportunity for freeing itself from the dictates and restraints of psychiatry.

Given opportunities to expand services beyond the physical boundaries of clinics and psychiatric wards, this same respondent felt that social workers less frequently found it necessary to assume such demeaning roles as "therapeutic assistants or finance messengers." Instead, social work was able to provide professional services with a new sense of independence, worth, and dignity. Thus, social work's near unanimous acceptance of the principle of command

consultation practice was seen by this respondent as a conscious, deliberate, and planned effort to disengage itself from the "shackles of psychiatry."

The sample as a whole was asked how they thought this relationship between social work and psychiatry affected the development of command consultation, to which 44 percent indicated that this relationship encouraged the development of command consultation. However, 29 percent believed that social work's relationship with psychiatry had an inhibiting effect on the development of command consultation, and 27 percent stated it had no effect. The significance of these minority opinions was best explained by one of the respondents who made this comment:

> . . . social workers experienced much difficulty breaking with the medical model when command consultation came along. Since command consultation involved leaving the office for long periods of time, the risk was great and many social workers did not take the risk but made a token gesture. My attitude is that social workers' strength was in our ability to operate in the community. I feel, and still do, that social work could enhance its profession with more consultation involvement, but it may mean a temporary loss of status. (respondent #754)

Respondents were then asked to comment on how the relationship between social work and psychiatry was influenced by the development of command consultation. It was noted by 69 percent of the respondents that command consultation tended to make social work less subordinate to psychiatry while just 3 percent thought it made social work more subordinate to psychiatry. Still, 28 percent stated

that the development of command consultation had no effect on the association between social work and psychiatry.

The survey highlighted additional feelings of resentment which some social workers felt, and it further described the low opinion with which Army social work was regarded. For example, one of the first social workers who served in World War II remembered being offered a commission if he would have agreed to accept the military occupational specialty title of "psychologist." He and most of his colleagues refused. Another respondent recalled writing several articles, only to have them published under the name and title of the psychiatrist in charge of the mental hygiene unit.[32]

Another of the subjects accounted for a sequence of events which occurred after command consultation had gained popularity and acceptance among social workers during the fifties and sixties—events which tend to support the notion that social work's search for autonomy was an important motivational force in the initiation of the program. For example, social work was established administratively as a separate service in 1967, and there naturally followed a corresponding increase in status for its members. When new social work positions were created in the expanding drug abuse and race relations programs, social work in the Army achieved further recognition. With social work providing

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[32]These accounts are not substantiated, but are presented to give insight into images which some social workers have vis-a-vis their past professional relationships.

leadership in developing the Army Community Services Program in the late sixties, esteem within the profession mounted still further. Presently, Army social workers hold prominent research, staff, administrative, and academic assignments which testify to the higher position accorded members of a profession who only a decade past had often been cast in unfavorable and demeaning images.

The members of the study sample were asked how they perceived the effect of social work achieving separate service status on its relationship with psychiatry. This status was cited by 73 percent as giving social work greater independence from psychiatry. Just a single respondent thought it made social work more heavily reliant on psychiatry, while 13 percent felt that becoming a separate service had no effect on social work's relationship with psychiatry; the remaining 13 percent had no knowledge of the historical event in which social work became administratively separate from psychiatry.

Again, referring to figure 2, it is clear that command consultation had its greatest rise up until the mid-sixties. Figure 2 further reveals a decline in the extent to which command consultation was practiced during the period of the late sixties and early seventies. It seems more than coincidental that the decline of command consultation occurred at the same moment in time that social work had achieved separate service status from psychiatry. And yet, when the

respondents were specifically asked how the achievement of separate service status affected Army social work in command consultation, 33 percent replied that command consultation activity "increased." Just 6 percent noted that command consultation practice decreased, while 30 percent reported that command consultation activity remained about the same. The concluding 31 percent stated that they had no knowledge of the event; and 5 respondents did not answer. Thus, respondents did not perceive the establishment of separate service status as a cause for command consultation's decline in the latter half of the sixties and the early seventies.

Yet, despite the respondents' replies to this question in the survey, it seems unlikely that the separation of social work service from psychiatry did not have some effect on the diffusion of command consultation. To begin, the respondents asserted that social work status was marginal in relation to psychiatry. Second, social workers grew increasingly disaffected by the roles and functions to which they were relegated by psychiatry. Third, command consultation practice afforded social workers an opportunity to become free of psychiatry's control. As a respondent commented: "It was a vehicle for emancipating social workers from the administratively subordinate position." He added: "When social workers discovered that command consultation enabled them to operate autonomously, they clutched it to their bosoms." In fact, social workers gained increased autonomy and prestige by virtue of their participation in command

consultation. Once separate service status was achieved, a strong influence and extrinsic motivation for doing command consultation was removed.[33] It would seem that the relationship between social work's severance from psychiatry's control and the concomitant reality of command consultation's decline was more than a coincidence. Udy accents the point:

> When anyone asserts that two things are related (in this case, command consultation practice and psychiatry's control), he is implicitly saying that he has somehow been led to believe that the association he has observed between them did not occur by chance.[34]

While the respondents who were involved in the study did not see the causal relationship of these events, the preponderance of evidence strongly indicates a probability that separation of social work from psychiatry was an overwhelming powerful event that led to the decline in command consultation interest and practice.

The findings and analysis in this chapter have dealt with five substantive areas. These included the overall experience of the social work respondents, the overall historical development of command consultation, the characteristics of the innovation itself, the degree to which it was

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[33]Thomas and Bennis note that ". . . an intangible gratification such as organizational or personal prestige may be a crucial incentive for essential members, and thus opportunities for enhancing the organization's social standing . . . will be the incentive resource in terms of which the benefits of a proposed innovation will be assessed," in Management of Change and Conflict (Baltimore: Penguin Books, 1972), p. 242.

[34]Stanley H. Udy, "Cross-Cultural Analysis: A Case Study," in Sociologists at Work, ed. Phillip E. Hammond (Garden City, N. Y.: Doubleday, 1967), p. 210.

institutionalized throughout the Army's MHCS, and the impact that social work's status as a profession had on command consultation's proliferation. The data and discussion presented in this chapter emphasized that no singular explanation could account for the difficulty encountered in the innovation's dissemination. Clearly, command consultation's introduction, development, and management were quite complex and influenced by a wide variety of forces.

CHAPTER V

SUMMARY AND CONCLUSIONS

The Research Issue

This study was initiated in the interest of gaining a more comprehensive understanding of the innovation process and its impact on society. Because of the magnitude of such an endeavor, the research problem was focused on a specific case example called command consultation. Command consultation, an innovation in the Army's Mental Hygiene Consultation Service, was identified in this study as the manifest topic for consideration; however, the predominant underlying concern throughout has been to explore how and with what success innovative endeavors in general are introduced, developed, and managed.

Command consultation, as its name explicitly states, is a consultation service to commanders—not a treatment service to the individually impaired soldier. The impetus for the command consultation movement came about during World War II when military psychiatrists, social workers, and psychologists began searching for a preventively oriented practice function for dealing with multiplying numbers of psycho/socially troubled soldiers. The conditions of combat

led practitioners to the realization that one-to-one clinical assistance directed toward the debilitated soldier did little to aid the much larger war effort. Subsequently, mental health practitioners began consulting with commanders and cadre so that the commanders themselves could ultimately become more adept in understanding, supporting, and resolving the emotional problems of their troops. The emerging practice function for achieving these goals came to be known as command consultation. Viewed as an innovation in the MHCS, command consultation was widely acclaimed to be worthwhile, and over the years, it was presented as a logical and reasonable strategy for providing mental health service, particularly because it had significant preventative possibilities. Information about command consultation spread throughout the Army mental health community, and practitioners began to speak about and carry out the new approach. A literature developed and the subject was discussed at conferences and meetings. Interest swelled dramatically through the fifties and into the early sixties.

However, the actual practice of command consultation never matched the widespread acclaim that it verbally received. While practitioners spoke about it and professed its value, few individuals practiced it. This report has shown that command consultation programs sprang up at various locations for relatively brief periods of time. When practitioners who had knowledge of and interest in command

consultation received reassignments or left the military, command consultation efforts typically disappeared from that particular location. *Command consultation* acquired a reputation for being sporadically practiced in the MHCS as it was almost totally dependent on the personality of the individual practitioner. Fragmentation of command consultation occurred in the mid-sixties and a steady decline followed into the early seventies.

The major question addressed in this study had to do with tracing the incongruity of command consultation's widespread appeal to practitioners as juxtaposed against its historically poor record for actual implementation. The dissonance between what mental health personnel verbalized about this innovation and the extent to which they truly engaged in it was central to this study. Understanding more about this apparent discrepancy and explaining the overall process by which command consultation was introduced and managed was the central focus of the problem.

The Research Method

The design of the research methodology aimed at developing a strategy for following a course of events through history. The original interest was to study the living history and human events surrounding the innovative process of command consultation. In order to sustain the qualitative richness of the question, the methodological approach was

grounded in the actual experiences of the innovators and early practitioners. These individuals alone were thought to have held the insight into what contributed to the present confusion surrounding command consultation activity. It was these decision makers who were therefore called upon to serve as witnesses in reconstructing the process which they lived and experienced. Their retrospective accounts established the basis for the research.

A preliminary exploratory phase was initiated in order to identify the key issues of the study, and to provide a beginning understanding of what may have led to the fragmentation and ultimate decline of the command consultation movement. Accordingly, the following steps were initiated: literature search, exploratory phone calls, correspondence, cassette tape recordings, personal interviews, and a pilot survey. These early steps enabled the investigator to identify a series of recurrent themes which described how command consultation was introduced and managed. After assessing these exploratory data, further verification was judged to be necessary. Therefore, a more extensive inquiry was developed and directed toward the larger population of Army social work officers. In order to comprehensively tap the experiences of this group, a full-scale survey was designed on the basis of the substantive issues that were identified in the preliminary exploratory phase. A series of screening, selection, and assessment procedures were subsequently undertaken. The

major concern of this process was to isolate a broad sample of Army social workers who possessed sufficient knowledge, experience, and qualifications to speak to the events surrounding command consultation's development. The method ultimately yielded a final study sample which consisted of 163 subjects.

Review of Findings and Conclusions

The primary thrust of this study was to explore the forces moderating against the successful diffusion and adoption of command consultation in the U.S. Army. The major findings are summarized below and a concluding discussion of the issues is presented. Five core questions were investigated and each of these questions were elaborated upon throughout chapter 4 of this investigation.

1. What was the overall experience of the social work respondents in relation to their involvement with command consultation?

Respondents reported substantially high levels of individual involvement, success, and satisfaction in their own practice of command consultation. However, their perception of the limited extent to which colleagues engaged in the practice of command consultation was in striking contrast to their own reputedly high levels of involvement.

Almost all respondents agreed that the ways in which they learned about command consultation were largely informal,

sporadic, spontaneous, and empirical in nature. "On the job work experience" was identified by 95 percent of the subjects as the most common way of learning about command consultation. Systematic, organizationally planned procedures for teaching command consultation were virtually non-existent.

Respondents stated that there was a total absence of formal command consultation orientation directed to incoming social workers at the Officer's Basic Course. Subjects also commented that it was unrealistic to expect that the master's degree level of social work education was adequate preparation for engaging in effective field consultation efforts with commanders and cadre. The findings in this study further revealed that many informal, in-service training programs existed at various MHCS facilities. However, these programs only served a useful purpose for the small numbers of practitioners who happened to be assigned to that unit. It may have been in the minds of those who conceived the program that since the practice function was of such utility, the process would spread by virtue of its attaining an increasingly favorable reputation. In retrospect, it is judged that such hopes and expectations were ill-conceived as evidenced by the absence of continuing command consultation programs today.

Attitudes of respondents toward command consultation were extraordinarily positive. When asked about their reaction to command consultation the first time they learned about it, 95 percent of the subjects said that it was "acceptable"

while only 5 percent thought it was "unacceptable." Most respondents mentioned that their attitudes toward command consultation remained positive and unchanged. Over time, however, 19 said that their attitude toward command consultation became less positive. Their comments were noteworthy: "No means for valid evaluation, technical problems in doing command consultation, too many limitations, its practice was a myth, preparation was inadequate, practitioners were inexperienced, and receptivity on the part of the recipient was unfavorable and unaccepting."

2. How did the general historical development of command consultation influence its diffusion through the military?

Subjects in the full-scale survey reported on their overall impressions of the extent to which command consultation was practiced, the degree to which it was understood, and the level of success that it achieved during the course of its development. A very distinctive pattern of development was in evidence as depicted in figure 2, page 124 of chapter IV. All three areas of inquiry—"practice, understanding, and success"—showed a consistent, steady rise beginning in the early fifties and continuing into the early sixties. Levels of practice, understanding, and success then peaked in the mid-sixties and began a steady, unrelenting decline into the early seventies. It was observed that the relatively limited levels of practice, understanding, and success in the fifties were directly attributable to the fact that command consultation was an innovative, emerging practice

function in the MHCS. However, the fact that it returned to similarly low levels in the seventies after enjoying relatively wide acceptance in the sixties documented the declining interest in command consultation and served to make evident its fragmentation.

3. What were the nature and characteristics of command consultation and what impact did these characteristics have on the proliferation of the innovation?

A wide range of opinion was presented by respondents in commenting on how they perceived the definition and principles of command consultation. In response to a question inviting respondents to identify the primary principles they associated with command consultation, over 517 collective principles were delineated. Of these, 49 percent were evaluated to be consistent and congruent with a baseline definition and 51 percent were regarded to be irrelevant, incongruous, or indicative of other mental health practice functions. While most subjects seemed to understand the essence of command consultation, it was evident from the data and comments that command consultation meant different things to different people. Mildred Erickson observed that social work consultants in mental health centers within the civilian community were also ". . . apt to have rather vague notions as to what consultation is, its objectives, types, definitions, and boundaries."[1] What was

[1]See "Consultation Practice in Community Mental Health Services" (D.S.W. dissertation, University of Southern California, 1966), p. 282.

particularly profound with regard to this matter was that respondents in the full-scale survey were not a randomly chosen sample of social workers; they were a selected group of the most qualified individuals who could speak to the issues of command consultation's dissemination. If, as the data reflect, uncertainty about the principles and definition of command consultation existed with this carefully chosen group, it was deduced that the larger universe of social work practitioners undoubtedly knew substantially less. The conclusion which followed from these data was that a consistent definition was never agreed upon and consequently, a common understanding of command consultation principles did not spread throughout the system.

Respondents were asked to identify other characteristics which interfered with the practice of command consultation. "Limited experience of mental health personnel doing command consultation" was the item respondents thought "interfered most strongly" with command consultation's success. Respondents largely agreed that because of the unique nature and characteristics of command consultation, special experience among the mental health practitioners was needed. And, as stated earlier, although respondents prided themselves on their own commitment to and involvement in command consultation, they believed their colleagues and associates were largely lacking in experience.

Continuity: "Frequent rotation of duty assignments and the resulting disruption in continuity" was cited as the second most relevant issue believed to be detrimental to command consultation's success. Because the fate of command consultation's adoption was strictly in the hands of the adopters and practitioners, it was understandable that the innovation swayed and vacilated according to the ever-present changes and rotations in their duty assignments.

Ideological commitment to the individual was an issue perceived by respondents to significantly interfere with the successful implementation of command consultation. When social workers were presented with the opportunity to engage in a new, preventive practice function called command consultation, an attendant conflict developed. The social workers inevitably discovered that in the course of doing consultation, the needs of the individual soldier were subordinated to the needs of the larger system or organization. Thus, the innovation was not merely the introduction of a novel and different operation in the MHCS; command consultation represented the alteration of an intrinsic professional value held by the majority of social workers who coincidentally happened to be casework-oriented practitioners. Given this finding, it became more understandable that respondents would cling to their traditional one-to-one casework functions, even though they could safely profess that the primary preventive mode called command consultation was the desired approach. And in fact, 93 percent of the respondents did

profess that command consultation was consistent with existing values of social work. Looking at the dichotomy between what they voiced to be desirable and the growing decline in actual practice, it is clear that substantial conflict either overt or covert existed in the minds of those individuals responsible for implementing command consultation programs.

The compatibility of command consultation with client (commander) needs was another factor which moderated against its successful diffusion. Typically, the data revealed that commanders were usually receptive to accepting assistance from the MHCS when it came to case consultation, i.e., working on problems of the individually impaired soldier. However, according to the study sample, receiving assistance on organizational issues was rarely understood by commanders to be a fruitful area of involvement. Of greatest significance is the fact that little was done to formally teach commanders about the existence of command consultation as a viable resource for looking at organizational matters. The data specifically showed that informal methods were the predominant ways that commanders typically learned about command consultation. Respondents widely agreed that formal methods should have been the proper course for conveying information about this program to the client group.

Complexity: The presence of varying levels of difficulty associated with command consultation was perceived by 75 percent of the subjects. Approximately 50 percent of the respondents indicated that the difficulty of the method

actually interfered with its practice. Given the characteristic level of difficulty, it was understandable that rapid integration into existing systems of practice was substantially more restricted than if the innovation were more simple to understand and conduct.

Rank Differences: Respondents identified rank differences between the consultant and consultee as a hinderance to command consultation's successful adoption. Seventy-two percent of the sample noted than rank differences had a "significant to moderate" effect on the consultation process. While respondents indicated that this impediment was comparatively small when evaluated within the context of other issues, rank differences stood out as an important element in the overall establishment of command consultation. The basic problem of managing roles and issues of authority was one that respondents identified as being a troublesome part of command consultation.

4. To what extent was command consultation institutionalized throughout the Army's mental hygiene consultation service?

A problem of command consultation and its intended dissemination had to do with the fact that it was internally conceived, managed, and practiced within the MHCS. The findings show that very little effort was ever made to involve external Army agencies or components in a plan for spreading it throughout the system. In other words, social work practitioners gathered from time to time at conferences, and they

presented papers about some conceptual or practical applications of command consultation. However, little development of strategy was ever reported in relation to how the idea might be formally institutionalized throughout the Army. Commanders were not formally introduced to the process. A formal Army regulation to legitimate command consultation's practice was never written. Concept, policy, and doctrine were never formally presented. What did exist from time to time at various Army posts were social work practitioners who individually believed and engaged in command consultation activity. In each case, the parameters for development of command consultation were limited by the practitioners' own ideas about how it could be most usefully operationalized.

This was undoubtedly a lonely task and one which produced relatively limited results in relation to the enormity of the overall objective, i.e., communicating it to the greater system. While the individual practitioner may have been successful in selling the idea to a single commander or one particular organizational unit, the relative impact throughout the much larger system was infinitesimal. Command consultation needed command support, and without it there was little chance that it could have succeeded as its founders hoped. On the basis of historical accounts provided by respondents in this study, virtually nothing was ever done by the early innovators or adopters to obtain this broader systems support. Hence, fragmentation of this innovation is dramatically in evidence.

5. What impact did social work's status as a profession have on the adoption of command consultation technology.

Findings in this study showed that the professional status of Army social work was a condition which had a distinct impact on how command consultation was received and on the extent to which it was practiced. Given social work's traditionally subordinate role to psychiatry, respondents were asked how they preceived their level of status in relation to Army psychiatry. As predicted, the unanimous opinion was that social workers perceived themselves to have significantly lower levels of status relative to psychiatry. The study findings further revealed that while social workers were somewhat accepting of this condition in the fifties, they became increasingly less tolerant of psychiatry's dominance as time passed.

Respondents were asked if the relationship between social work and psychiatry tended to encourage the development of command consultation, especially because this new mode offered Army social workers a practice function which could serve as a means of achieving professional autonomy. While 29 percent of the subjects thought the relationship between social work and psychiatry "inhibited" the development, 44 percent agreed that social work's subordinate position tended to encourage it. Of the most significance, 69 percent of the respondents then stated that command consultation tended to make social work less subordinate to psychiatry. And so, command consultation practice grew throughout the sixties

and as it matured, the intensity with which social workers perceived their subordination to psychiatry diminished.

The establishment of separate service status for social work in the latter half of the sixties represented a turning point for Army social work because it officially permitted social work to function independently from psychiatry. Interestingly, after social work attained its independence from psychiatry, levels of command consultation activity tapered off considerably. The linkage between command consultation practice and social work's struggle to gain professional self-reliance was a key finding in this investigation. The idea that the innovation called command consultation afforded social work an opportunity to free itself from the constraints of psychiatry was a major incentive for carrying the movement forward. Given the acquisition of separate service status and the attendant recognition of new found worth, Army social work no longer required the command consultation function as an avenue for professional assertion. Interestingly, few respondents in the study perceived the causal relationship between these circumstances. Nevertheless, the study data support the conclusion that social work's marginal status as a profession was an influential force which drove command consultation practice. Army social work's subsequent attainment of new found levels of status and recognition eliminated an important incentive and motivation for engaging in command consultation operations. This was reasoned to be a singularly important event

which helped to account for declining interest in command consultation practice.

Recommendations and Suggestions for Future Research

A significant, basic continuation of the command consultation idea has occurred in another subsystem of the U.S. Army outside of the MHCS. Existing now as a modification or alteration of its parent practice, a new and distinctly separate program called "organizational effectiveness" (OE) has been introduced as a resource of the seventies for Army commanders and managers to maximally enhance their organization. Essentially, the OE program is similar to the command consultation movement in that it is also a preventively oriented consulting process directed toward improving the functioning of an organization. The basic principles, concepts, and approaches for both programs are much the same. The primary difference is that command consultation has developed around a mental health or medical consultation model whereas the OE program focuses on a management orientation toward consultation. The approaches parallel each other very closely, and it is often stated that except for the language and jargon used to describe each program, it would be difficult to differentiate organizational effectiveness operations from those of command consultation.

Briefly, organizational effectiveness programs came about during the mid-seventies when a group of U.S. Army officers attended graduate schools of business administration and

gained familiarity with new management and consulting technologies. These officers presented their thoughts to the appropriate military authorities and suggested that many of the concepts and practices used in industry and private enterprise might also have application in the military. Subsequently, a series of pilot projects were instituted to determine if these ideas had potential value to the military.

The pilot projects were judged to be successful, and during the course of the subsequent years, an extensive consulting program was established throughout the U.S. Army. The essence of this program and the parallels it shares with its predecessor, command consultation, constitute a continuation of an idea that had its birth more than thirty years ago.[2]

And so, an innovation similar to command consultation has emerged with the basic similarities of a preventive systems-oriented philosophy. Interestingly, the process by which organizational effectiveness programs have evolved consists of some unique and substantive differences in comparison to the manner in which command consultation progressed. For example, a formal Army regulation has been written to officially sanction and mandate OE's presence.[3] A sixteen-week

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[2]A more elaborate discussion of the historical development of organizational effectiveness can be found in the following: "Organizational Effectiveness in the US Army," Final Report of the Organizational Effectiveness Study Group, Office of the Chief of Staff, Department of the Army, Washington, D.C., April 1977, doc. no. ADA 043 500.

[3]See Army Regulation 600-76, "Organizational Effectiveness Activities and Training," Department of the Army, Washington, D.C., November 8, 1977.

training program has been established for the specific purpose of formally educating individuals regarding organizational effectiveness concepts, methods, and processes.[4] The former Chief of Staff of the Army, General Bernard Rogers, has on numerous occasions spoken of adopting the OE program as his own stating that ". . . it will be his legacy to the Army."[5] These illustrations of training, sanctions, and backing are clear aspects of institutionalization that command consultation programs never received.

Still, institutionalization alone does not guarantee the successful diffusion and adoption of an innovation. Organizational effectiveness programs have been in effect for about four years, and now questions about its future are being raised. Issues over funding, training, policy, research, and evaluation are subjects of continuing concern. As these final comments are being written for this study, the OE program budget is undergoing congressional scrutiny because the program has not yet been able to convincingly demonstrate that it is a cost effective program. Research efforts are underway to produce verifiable and valid measures for documenting OE's value. In terms of utilization, the majority of practitioners typically stay in the program for relatively brief periods of 18 to 24 months and then move on to other assignments. These

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[4]This training program is conducted at the Organizational Effectiveness Center and School, Fort Ord, California.

[5]Fred W. Schaum, Lieutenant Colonel, U.S. Army, interview, November 1979. Lt. Col. Schaum served as the Assistant to the Chief of Staff of the Army for Organizational Effectiveness from 1977 to 1979.

and other aspects of the OE program may be signs of change for this innovation and may call into question many of the same concerns that were commonly raised by those associated with the consultation experience of earlier decades. Thus, questions such as the following might be presented for future consideration and study.

(a) What parallels exist between the command consultation program of the MHCS and the organizational effectiveness program for the U.S. Army as a whole? What lessons might be learned from command consultation that would benefit the organizational effectiveness program. Conversely, what lessons might be learned from organizational effectiveness that might be of value in reviving command consultation?

(b) Do preventively oriented, systems approaches for dealing with organizational issues find acceptance in the Army or does a basically inhospitable ideology render them inoperative after periods of relatively brief acceptance?

(c) Do organizational constraints or broader social forces exist in the Army which transcend and therefore limit the ability of innovators to effectively plan for and insure the successful adoption/diffusion of an innovation?

The innovation discussed in this investigation, command consultation, is a distinct practice function that is oriented to the broader organizational system rather than to the impaired soldier. It is therefore suggested that an inherent ideological conflict arises for Army social work practitioners whose practice commitment may focus more directly on the

individual. Throughout this study, reference has been made to the fact that a disproportionate number of Army social workers are, by graduate social work training, casework practitioners. On the other hand, command consultation is a community, systems, or organizationally based methodology. The implication to this study is that if Army social work practice is most appropriately conducted on a one-to-one individual basis, then it would be logical for there to be a large number of Army social workers who are predominantly caseworkers. However, if the fundamental program rational for Army social work is in the area of primary prevention, a critical assessment needs to be made about what type of social work specialization is required for insuring that proper, specialized expertise is present in the system. Therefore, a fruitful arena of study might address the following issues:

(a) On what future goal does Army social work focus its service commitment?

(b) Should the existing, heavy recruiting of casework practitioners for Army social work be maintained?

(c) If future directions for the recruitment are aimed at expanding the numbers of community organization practitioners, what kind of policies and procedures would be necessary?

It is axiomatic that if an innovation is to diffuse throughout a social system, prospective practitioners must be informed about its existence and must be instructed on how to do it. While the findings have shown that informal

procedures did exist at various locations to teach mental health personnel something about command consultation, a systematic, organizationally planned procedure was certainly lacking. If a service function is deemed to be of value to a system, then institutionalized processes must be instilled so that the idea would have greater potential for gaining greater acceptance in the system. Findings in this study have demonstrated that localized, in-service training procedures were not sufficient to insure widespread adoption of command consultation. Measures such as the following should be undertaken in order to systematically inform Army social workers about the values and techniques that are associated with command consultation.

1. Establish a formal block of command consultation instruction for incoming Army social work officers during their basic orientation course at Fort Sam Houston, Texas.
2. Extrapolate from the existing literature concepts, policies, and procedures for teaching practitioners about how to do command consultation.
3. Develop workshops or training seminars for individuals to systematically learn about command consultation procedures.
4. Emphasize refresher training in command consultation during the Officers Advanced Course at Fort Sam Houston, Texas. This instruction normally occurs between the fifth and tenth year of an officer's career in the military and would be a timely occasion for this individual to formally evaluate practice skills, knowledge, and so forth.

Another proposition developed in this investigation that should be self-evident is that in order for an innovation to gain credibility and acceptance, recipients of service must know about its presence. Findings pointed out that recipients rarely understood that command consultation processes were directed to organizational problems or systems-oriented issues. Commanders typically perceived the MHCS as a resource for getting assistance with emotionally or socially impaired soldiers. Moreover, this assistance was normally related to either administratively processing such individuals out of the military or to treatment endeavors. Another thrust of command consultation, one which is little understood or appreciated by commanders, is that the ". . . socio-cultural dynamics of the organization are relevant, no less than the inter-psychic dynamics of the individual soldier."[6] For command consultation to succeed and gain acceptance, it is essential that the recipients, namely commanders and cadre, obtain formal factual guidelines about consultation.

It was mentioned in this study that Army social work did not have an exclusive hold on the conceptualization or practice of command consultation. It is important to restate that Army psychiatrists and psychologists contributed substantially to the command consultation movement. While this study was specifically limited to presenting Army social work's role in this innovative process, future research

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[6]Edward L. Maillet, "A Study of the Readiness of Troop Commanders to Use the Services of the Army Mental Hygiene Consultation Service" (D.S.W. dissertation, The Catholic University of America, 1966), p. 182.

should investigate the respective roles assumed by Army psychiatry and psychology.

A need exists for additional study of command consultation's processes and techniques. Further study of the major differences between unit consultation, case consultation, administrative consultation, and so on, would help to erase much of the existing confusion in practitioners' minds about what they are actually expected to accomplish.

Finally, there is a necessity to find ways of evaluating the results of command consultation. Perhaps, the strongest criticism leveled against command consultation is that there is an absence of hard, measurable data to document its value. Future research may best serve command consultation if the major focus were aimed at developing tools and valid measures to judge the effectiveness of the work.

Conclusion

The extent to which respondents in this study reported that they valued the conceptual basis of command consultation was extraordinary. The high levels of praise and recognition given to command consultation's worth was nearly universal. However, on the basis of the findings presented in this study, it is evident that a significant disparity existed between how respondents stated that they valued command consultation and the extent to which they ultimately engaged in the practice. Moreover, it is profound that key participants claimed

that they themselves practiced the preventive function known as command consultation, but others did not. Specifically, respondents who were asked to comment on their own actions described relatively healthy and substantive accounts of viable command consultation activities. But when the same respondents reported about how they perceived command consultation in the larger community of Army mental health activity, it would seem that command consultation had simply evaporated. What the historical facts show is that a viable command consultation program did in fact exist in the late fifties and into the early sixties. The literature and verbal accounts of the times adequately support this conclusion. However, there is little to document that bona-fide command consultation programs survived into the early 1970s. In fact, the program has fallen into disuse and had become fragmented to such a degree that its existence is now barely recognizable.

Thus, this study has dealt with the task of accounting for the gap between what respondents say they valued and what they in fact did value that could be institutionally regarded as a well-integrated, on-going command consultation activity. One of the major conclusions drawn from the descriptive accounts of this study is that command consultation was once a legitimate, viable practice modality in the MHCS but has now virtually vanished, taking on the character of an illusion in the minds of social work practitioners who may remember command consultation with nostalgia.

During the period of time in which it was practiced, command consultation had an alliance of followers who met at Army social work conferences, presented papers, and rallied around an innovative systems approach for settling mental health difficulties of impaired soldiers. While the movement enjoyed great respectability at this time, it must be concluded that this high regard was mainly from within the inner circles of mental health practitioners. Outside recognition and sanctions simply never developed and as a consequence, the innovation was incomplete.

The dramatic decline in interest throughout the latter half of the sixties and into the early seventies demonstrates vividly the fragmentation of command consultation. The subject is now seldom discussed at conferences, and genuine command consultation programs in the MHCS are the exception. Professional activities in the MHCS have gone in different directions, for the most part returning to an active clinical focus with attention centered basically on the individual. From time to time, a former believer or practitioner will have something to say about how worthy command consultation was in the past, and few will disagree. At other times, a newcomer to the MHCS will develop a field consultation model and call it a new, innovative, preventive service to command. And so it is that MHCS practitioners continue to "re-invent the wheel." Command consultation practice now basically exists as a repetitive, cyclic practice which springs up spontaneously in a given location only to die out shortly

thereafter. The conclusion is clear that the discontinuity in this process dramatizes the degree to which command consultation's successful diffusion has been obstructed.

The case of command consultation has been presented as a specific illustration of how innovations in general win approval and diffuse throughout a social system or how they may incur disfavor and ultimately disappear. It has been shown that the early interest of innovators and other proponents was sufficient to initiate substantial momentum in introducing a social movement. While enthusiasm normally prevails among the advocates of an innovation and may persist for periods of time, it is not a substitute for definitive institutionalization. The nature of such institutionalization must progress to a firmly rooted place within the larger social system in which it is established. This should include clearly defined doctrine and policy, well-established training and education, comprehensive methodologies for implementation, and valid procedures for evaluating success.

Yet, as this study has shown, it may not be realistic or practical to believe that every innovation or social movement lives forever. This study has illustrated how an innovation had its birth within an atmosphere that was initially conducive to this particular kind of change. And still, it is inevitable that with the passage of time, new interests and needs emerge, thus producing a different climate that is often less and less hospitable to the original innovation. So no matter how valid a change movement seems at a

particular moment in time, and no matter how sound the new technology it is advancing appears, new circumstances and forces continually redefine the life of the innovation. Thus, innovations retain their momentum for varying lengths of time, but ultimately give way to other needs within the system.

This study further demonstrated how complex and difficult it is to effect change. It has been suggested throughout that the difficulties of change are due in large part to the persistence of both the system and its members to retain that which is familiar. Machiavelli spoke of the issue over four hundred years ago:

> It must be considered that there is nothing more difficult [illegible] more doubtful of success, nor more dangerout to handle, than to initiate a new order of things. For the reformer has enemies in all those who profit by the old order, and only lukewarm defenders in all those who would profit by the new order, this lukewarmness arising partly from fear of their adversaries, who have the laws in their favour; and partly from the incredulity of mankind, who do not truly believe in anything new until they have had actual experience of it. Thus it arises that on every opportunity for attacking the reformer, his opponents do so with the zeal of partisans, the others only defend him halfheartedly, so that between them he runs great danger.[7]

Finally, innovations set off complex series of processes that never allow the system to return to its exact, previous state. The innovation has created something new within the social system so that it is to some extent transformed. And it is ". . . this transmission to the succeeding generations of basic constants . . ."[8] that creates a forever changing culture.

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[7]From The Prince, written in approximately 1513, trans. Luigi Ricci, rev. E. R. P. Vincent (New York: New American Library of World Literature, 1952), p. 55.

[8]Victor Vasserely, Vasserely 3 (Neuchatel, Switzerland: Du Griffon, 1974).

APPENDIX A

LETTER OF INSTRUCTION FOR PRELIMINARY QUESTIONNAIRE

406-B Murray Avenue
Fort
20 June 197

Dear Social Work Colleague:

It has been several months since you shared with me some of your experiences associated with the early developments of command consultation. At the time of our talk, I asked for your further indulgence and cooperation in completing a follow-up questionnaire.

Much of the initial information which you provided in our talk has now been incorporated into the present study. You will find that the enclosed questionnaire will contain many familiar ideas. I am asking you at this time to further expand on these ideas and provide additional clarification.

I am aware that this task may be somewhat time consuming, and I apologize for this imposition. Your detailed responses are, however, critical to the success of the current project. You have my assurances that your comments will be read only by myself in order to maintain absolute confidentiality. The return envelope is numbered to enable me in determining who has or has not returned his questionnaire.

The questionnaire should take approximately one and a half hours to complete. Please return the questionnaire within five days in the self-addressed, return envelope. Instructions and explanatory information precede each section of the questionnaire. Feel free to comment on any question. Complete the Baker-Schulbert CMHI Scale before you answer the information questionnaire.

Several of you generously lent me conference proceedings and professional papers from your personal files. I am making use of this material and will return it to you as soon as possible.

I appreciate the time you are taking on my behalf, and I thank you for your cooperation.

Sincerely yours,

Paul F. Brenner

Paul F. Brenner
Cpt. MSC
United States Army
Doctoral Student

APPENDIX B

LETTER TO SELECTED ARMY PSYCHIATRISTS AND PSYCHOLOGISTS

406-B Murray Avenue
Fort
25 July 197

Dr. _____, Col/ret.

Dear Dr. _____:

Regarding our telephone conversation of 23 July, I am writing this letter to you in order to learn of your current views and feelings toward command consultation practice. As we discussed I am currently conducting a research project on command consultation in the US Army's Mental Hygiene Consultation Service. This study is supported by the Medical Research and Development Command and is one of the requirements of my social work doctoral degree at Yeshiva University, New York.

I have recently completed the pilot phase of this study, and several questions have been generated from the data. I am hoping that you will have time to reflect and comment on some of the issues. I have enclosed a cassette tape with the hope that you might find this a convenient and quick method to respond to my questions. If you prefer, your written comments would be equally welcome.

The accompanying sheet contains several substantive areas which I would like you to address in your remarks. It would be helpful if you deal with each area as fully as possible before moving on to the next topic.

At the recent Current Trends Short Course in Army Social Work, a colleague summarized an afternoon session with the following statement: "We have been discussing these issues about command consultation five, ten and fifteen years ago, and it seems to me that we are saying the same things now that we were saying then." This quotation was frequently verbalized at the conference and it dramatizes the problem I am studying. I am investigating the command consultation function in relation to the repetitive, cyclical movement that has taken place since its origin. The study is framed within an historical perspective and since you are regarded as one of the early planners and participants, your contribution is most important.

Thank you for your time and cooperation.

Sincerely,

Paul F Brenner

Paul F. Brenner
Cpt. MSC
United States Army
Doctoral Student

COMMAND CONSULTATION ISSUES

I. It has been suggested that the practice of command consultation has not attained the level of success that was predicted for it during its development. How do you regard the overall development and success of command consultation (CC), particularly in relation to how it has or has not become widely operationalized? How extensively do you believe it was practiced during the time you were associated with the military? How widely accepted had it been among the three primary disciplines—psychiatry, social work and psychology? To what extent do you feel all Army mental health personnel in actuality conducted CC activity? Elaborate on the details of why command consultation had or had not been consistently and permanently operationalized (1) over time and (2) in all places where the practice was deemed to be most appropriately utilized.

II. It has been put forth that Army mental health personnel primarily rely on the informal, spontaneous outlets for learning about CC. Do you agree with this suggestion or do you feel that there have been efficient and effective means by which social workers, psychiatrists, and psychologists systematically learn how to do CC? Please discuss as many of the sources of learning and describe what impact each has had on the development of the total program. Further, do you think that mental health personnel are sufficiently knowledgeable of the principles and techniques to effectively practice CC? Comment briefly on these principles and techniques.

III. A third trend in the pilot phase of the study has suggested that the relationship between social work and psychiatry had an impact on the development of CC, particularly prior to the late sixties when social work was established as a separate service. Specifically, it was asserted that because social work had not attained the professional status or autonomy which psychiatry and psychology had achieved, CC activity offered social workers a new role which provided them with opportunities for enhancing their professional standing. Moreover, it has been presented in a few instances that some social workers resented the relationship with psychiatry and this further spurred the development of command consultation. What is your opinion regarding the validity of such thoughts?

IV. The degree to which CC practice has been "institutionalized," that is, formally integrated into the established organizational structure of military mental health services, has come into question. Do you believe that CC has been effectively institutionalized? To what extent has this been so at the following organizational levels: (a) Department of Army, (b) Surgeon General's Office, (c) Post Command Structure? How thoroughly do Army policy and official directives describe CC? What need is there (if any) for the larger organization to verify that CC activity is carried out? If you feel there is or has been a need, has there been an effective means to do this?

V. Please feel free to discuss any other area of CC that you feel is relevant.

APPENDIX C

FULL SCALE STUDY SURVEY

Code Number: _____

406-8 Murray Avenue
Fort Totten, New York 11359
11 October 1974

Dear Social Work Colleague:

I am requesting your participation in a research project on the command consultation function in the United States Army's mental health services. This study is approved by the Social Service Consultant to the Surgeon General, is supported by the Medical Research and Development Command, and is one of the requirements for my Doctoral degree at Yeshiva University. You have been selected to assist me in this study because you are one of the individuals who was practicing social work in the Army during the development of command consultation activity.

At the last Current Trends Course in Army Social Work, a colleague summarized a seminar with the following statement: "We were discussing these issues about the mental health services five, ten and fifteen years ago, and it seems to me that we are saying the same things now that we were saying then." Later, another associate remarked at the banquet: "You know, except for the new acronyms we use in the Army, it seems that little has really changed."

This theme so frequently verbalized at the conference, dramatizes the problem which I am studying. I am investigating the command consultation function in relation to the cyclic movement that has taken place since its origin. You have been chosen as a participant in this study because you are regarded as one of the participants, observers, or originators of command consultation. This questionnaire is designed to enable you to reflect on your experiences or observations of command consultation with the expectation that your responses will help to explain why we seem to be continuously "re-discovering the wheel."

You have my assurances that your responses will be strictly confidential. The number on the questionnaire will be used solely for follow up letters. Please return the completed instrument within five to seven days in the self-addressed, return envelope. Instructions and explanatory information precede each section of the questionnaire.

The objective originally sought in the preparation of this study was to conduct personal interviews. Geographical and financial considerations made this goal impossible to realize. The topic under study is highly complex and there are a wide range of experiences among Army social workers. In order to adequately examine the issues, the questionnaire is somewhat lengthy. It is hoped, however, that you will understand the reasons for this. I know that your time is valuable, so I therefore extend my appreciation to you for the assistance you provide in this project.

Sincerely,

Paul F. Brenner

Paul F. Brenner
Captain, MSC
Social Worker

INSTRUCTIONS: CODE NUMBER: _____

A. Please answer all questions as completely as possible.

B. Do not omit any question or part of a question unless it specifically does not pertain to you.

C. In all instances where you cannot respond because you were not in the Army social work program during a given period, write N/A for not applicable.

D. Please write as clearly as possible.

E. Answer each question in its proper sequence. Try to avoid interuptions while working on the questionnaire.

F. The scope of the subject command consultation is very broad and it is not presumed that this questionnaire can adequately account for everyone's unique, individualized experience. In those instances where you feel that you want to further elaborate on any question, you are encouraged to do so by utilizing the backs of the pages. (Be sure to refer to the number of the question upon which you are providing additional comments.)

Statement:

Army social workers have had diverse learning experiences regarding command consultation. The questions below seek to assess your early experience.

DO NOT WRITE IN THIS SPACE

1. In what year did you first learn about command consultation?

_____ 11-12

2. Name the place where you first learned about command consultation. (example: Ft. Ord, Walter Reed, etc.)

_____ 13-14

3. Identify the setting where you first learned about command consultation. (example: MHCS, correctional, division, etc.) 15

_____

4. From whom did you initially learn command consultation practice? (Cite name(s) and profession) 16-18 19

_____ _____
(name) (profession)

20-22 23

_____ _____
(name) (profession)

5. Describe how you first learned about command consultation.

24

25

26

6. How did you react to the concept of command consultation when you first learned about it? 27

I found it to be... a.____highly acceptable (1)
b.____somewhat acceptable (2)
c.____somewhat unacceptable (3)
d.____highly unacceptable (4)

7. Briefly comment on the reasons for your answer to question # 6. 28-33

8. Did your attitude toward command consultation change in regard to question # 6? 34

a.____yes (1)

b.____no (2)

9. If your answer in question # 8 was "yes", how did it change? 35
36

10. To what do you attribute the change? 37
38
39

11. When you were called upon to do command consultation for the first time, or when you had the opportunity to engage in command consultation for the first time, were you prepared for your role? 40

I was... a.____well prepared (1)
b.____somewhat prepared (2)
c.____somewhat unprepared (3)
d.____highly unprepared (4)

12. In retrospect, how could you have been better prepared? 41
42
43

13. List your experiences with command consultation. (List chronologically and include the experience you referred to in earlier questions.)

EXAMPLE:	DATE	POST	SETTING	ROLE
a. 1st Experience	'58	Ft. Dix	Stokade	WORKER
b. 2nd Experience	'60	Ft. Polk	MHCS	Supervisor
c. 3rd Experience	'64	Ft. Sam Houston	School	Teacher
d. 4th Experience	'67	Viet Nam	Division	Chief
•	•	•	•	•

PLEASE LIST:	DATE	POST	SETTING	ROLE	
a. 1st Experience					44-52
b. 2nd Experience					53-61
c. 3rd Experience					62-70
d. 4th Experience					71-75 c.2 11-14
e. 5th Experience					15-23
f. 6th Experience					24-32

14. Referring to the experiences you cited in question # 13 above, what was the nature of your involvement in each instance. (Check a response for each experience you identified above.)

	PARTICIPANT	OBSERVER	ORGANIZER	
a. 1st Experience	___	___	___	33
b. 2nd Experience	___	___	___	34
c. 3rd Experience	___	___	___	35
d. 4th Experience	___	___	___	36
e. 5th Experience	___	___	___	37
f. 6th Experience	___	___	___	38

15. Again referring to your command consultation experiences listed above, what was the extent of your knowledge of command consultation?

	NO KNOWLEDGE	LITTLE KNOWLEDGE	SOME KNOWLEDGE	CONSIDERABLE KNOWLEDGE	
a. 1st Experience	___	___	___	___	39
b. 2nd Experience	___	___	___	___	40
c. 3rd Experience	___	___	___	___	41
d. 4th Experience	___	___	___	___	42
e. 5th Experience	___	___	___	___	43
f. 6th Experience	___	___	___	___	44

16. During each experience cited in question # 13, to what degree did you practice command consultation? (Mark a response for each experience applicable.)

	PRACTICED EXCLUSIVELY	PRACTICED FREQUENTLY	PRACTICED OCCASIONALLY	PRACTICED RARELY	
a. 1st Experience	—	—	—	—	45
b. 2nd Experience	—	—	—	—	46
c. 3rd Experience	—	—	—	—	47
d. 4th Experience	—	—	—	—	48
e. 5th Experience	—	—	—	—	49
f. 6th Experience	—	—	—	—	50

17. What level of success was achieved regarding each overall command consultation effort? (Please refer again to experiences cited in question #13 and check a response for each.)

	HIGHLY SUCCESSFUL	SOMEWHAT SUCCESSFUL	SOMEWHAT UNSUCCESSFUL	HIGHLY UNSUCCESSFUL	
a. 1st Experience	—	—	—	—	51
b. 2nd Experience	—	—	—	—	52
c. 3rd Experience	—	—	—	—	53
d. 4th Experience	—	—	—	—	54
e. 5th Experience	—	—	—	—	55
f. 6th Experience	—	—	—	—	56

18. What degree of satisfaction did you derive from each of the experiences? (See question #13.)

	GREAT SATISFACTION	MODERATE SATISFACTION	MODERATE DISSATISFACTION	GREAT DISSATISFACTION	
a. 1st Experience	—	—	—	—	57
b. 2nd Experience	—	—	—	—	58
c. 3rd Experience	—	—	—	—	59
d. 4th Experience	—	—	—	—	60
e. 5th Experience	—	—	—	—	61
f. 6th Experience	—	—	—	—	62

19. During your Army social work career, to what extent did you influence the groups listed below by formally or informally teaching them about command consultation? (Check a response for each grop.)

	NEVER INFLUENCED	SELDOM INFLUENCED	OCCASIONALLY INFLUENCED	FREQUENTLY INFLUENCED	
a. Social Work Techs	—	—	—	—	63
b. Psychiatry Residents	—	—	—	—	64
c. Psychiatrists	—	—	—	—	65

(CONTINUED)

(19) (Continued from previous page)

	NEVER INFLUENCED	SELDOM INFLUENCED	OCCASIONALLY INFLUENCED	FREQUENTLY INFLUENCED	
d. Social work officers	___	___	___	___	66
e. Persons attending conferences	___	___	___	___	67
f. Other para-professionals	___	___	___	___	68

20. Check the statement(s) which most closely apply to your experience with command consultation.

a. ___ Because of the nature of my assignments, I was never exposed to the direct practice of command consultation.

b. ___ While I was exposed to command consultation, I chose not to participate. 69

c. ___ I participated in command consultation <u>after</u> I saw from the experiences of my colleagues that it was a useful function. 70

d. ___ I participated in command consultation <u>before</u> most of my social work colleagues. 71

e. ___ I was an earlier planner/promulgator of command consultation theory. 72

f. ___ I was an organizer of command consultation programs. 73

21. If you checked the response lettered "a" in question # 20, please mark one of the following statements: 74

a. ___ Although my assignments never exposed me to the direct practice of command consultation, I knew about this activity from observations, colleagues, conferences, papers, the literature, etc. (1)

b. ___ Since my assignments never offered exposure to the direct practice of command consultation, I never heard anything about it and am therefore totally unfamiliar with the activity. (2)

22. What impact did the following items have in determining the extent to which <u>you learned about command consultation</u>. (Check a response for every item.)

	STRONG IMPACT	MODERATE IMPACT	SLIGHT IMPACT	NO IMPACT	
a. Professional social work meetings and conferences.	___	___	___	___	75 c.)
b. Official directives or regulations.	___	___	___	___	11
c. Informal discussion with social work colleagues.	___	___	___	___	12
d. Guidance from the Social Service Consultant, SGO.	___	___	___	___	13
e. Formal orientation courses upon entry into the Army Social Work Program.	___	___	___	___	14
f. Guidance from senior social worker.	___	___	___	___	15
g. Guidance from senior psychiatrist.	___	___	___	___	16
h. In-service training programs.	___	___	___	___	17
i. The literature.	___	___	___	___	18
j. On the job work experience.	___	___	___	___	19

(continued)

(question # 22, continued from previous page)

	STRONG IMPACT	MODERATE IMPACT	SLIGHT IMPACT	NO IMPACT	
k. Social work graduate education	___	___	___	___	20
l. Prior civilian job exposure	___	___	___	___	21
m. Extended civilian education training institutes, etc.	___	___	___	___	22
n. Proceedings from professional meetings or conference papers	___	___	___	___	23
o. Guidance from the Psychiatry Consultant, SGO	___	___	___	___	24
p. Other (specify): _____	___	___	___	___	25

23. I would characterize my initial learning experiences with command consultation in one of the following ways: (Check one answer) 26

a. ____ Highly systematic and organizationally planned (1)

b. ____ Somewhat systematic and organizationally planned (2)

c. ____ Somewhat informal, sporadic or spontaneous (3)

d. ____ Highly informal, sporadic or spontaneous (4)

* * * * *

STATEMENT:

The following questions ask about the general development of command consultation throughout the mental health services of the Army. It is understood that your experiences may have been limited to specific places. The next group of questions seek to determine your general, overall impressions of the status of command consultation.

24. How do you evaluate the overall development of command consultation? (Answer only for the time periods during which you have had either association with or knowledge of command consultation.)

	HIGHLY SUCCESSFUL	SOMEWHAT SUCCESSFUL	SOMEWHAT UNSUCCESSFUL	HIGHLY UNSUCCESSFUL	
a. Early 1950's	___	___	___	___	27
b. Late 1950's	___	___	___	___	28
c. Early 1960's	___	___	___	___	29
d. Late 1960's	___	___	___	___	30
e. 1970's	___	___	___	___	31

25. To what extent do you think command consultation was generally understood among most Army social workers during each of the following periods? (Answer only for those periods applicable to you.)

	LARGELY UNDERSTOOD	SOMEWHAT UNDERSTOOD	SOMEWHAT MISUNDERSTOOD	LARGELY MISUNDERSTOOD	
a. Early 1950's	___	___	___	___	32
b. Late 1950's	___	___	___	___	33
c. Early 1960's	___	___	___	___	34
d. Late 1960's	___	___	___	___	35
e. 1970's	___	___	___	___	36

26. To what extent do you believe command consultation was generally practiced by most Army social workers during each of the following time periods? (Write N/A in those time periods not applicable to you.)

	WIDELY PRACTICED	OCCASIONALLY PRACTICED	RARELY PRACTICED	WIDELY NOT PRACTICED	
a. Early 1950's	____	____	____	____	37
b. Late 1950's	____	____	____	____	38
c. Early 1960's	____	____	____	____	39
d. Late 1960's	____	____	____	____	40
e. 1970's	____	____	____	____	41

27. To what degree has command consultation been adopted as a practice function in each of the following Army social work settings? (Please do not omit any responses.)

	FREQUENTLY ADOPTED	OFTEN ADOPTED	OCCASIONALLY ADOPTED	RARELY ADOPTED	NEVER ADOPTED	
a. MHCS	____	____	____	____	____	42
b. Army Community Services	____	____	____	____	____	43
c. Corrections	____	____	____	____	____	44
d. Division	____	____	____	____	____	45
e. CLASS II General Hospitals	____	____	____	____	____	46
f. Medical Field Service School	____	____	____	____	____	47
g. Staff positions i.e., DOD, DA SGO, etc.	____	____	____	____	____	48
h. KO Teams - Field Hospitals	____	____	____	____	____	49

* * * * *

STATEMENT:

The next series of questions seek to assess your opinion of command consultation and to evaluate some of its characteristics.

28. What degree of difficulty do you as a social worker associate with command consultation? 50

a. _____Very difficult to do (1)
b. _____Moderately difficult to do (2)
c. _____Somewhat difficult to do (3)
d. _____Not difficult to do (4)

29. SHould any professional Army social work officer be knowledgeable about and capable of performing command consultation if called upon to do so? 51

a. _____yes (1)
b. _____no (2)

30. It has been suggested that in order for practioneers to do command consultation effectively, an 'intuitive feel for the process' is essential. What is your view? 52

a. _____I strongly agree (1)
b. _____I moderately agree (2)
c. _____I moderately disagree (3)
d. _____I strongly disagree (4)

31. How do you think the principles associated with command consultation have been defined? 53

a. _____undefined (1)
b. _____poorly defined (2)
c. _____somewhat defined (3)
d. _____well defined (4)

32. Please list the primary principles which you identify with command consultation. (Please write clearly) 54-66

33. The two types of command consultation most commonly identified are "case consultation" and "unit consultation." Which type of command consultation have you most often practiced? 67

a. _____case consultation (1)
b. _____unit consultation (2)
c. _____practiced equally (3)

34. List additional types of command consultation which you have practiced. 68-72

35. Which of the following benefit the most from effective command consultation services? (Rank all items by writing the number # 1 for that which benefits most, the number # 2 for that which benefits second, etc.)

a. _____the individual soldier 73
b. _____the unit 74
c. _____the commander 75
d. _____the social worker consultant 11-c.4
e. _____the mental health unit (MHCS) 12
f. _____the Army 13

36. Is command consultation as you understand it consistent with existing values of social work? 14

a. _____highly consistent (1)
b. _____somewhat consistent (2)
c. _____somewhat inconsistent (3)
d. _____highly inconsistent (4)

37. To what extent do you feel that "rank differences" generally effect the consultation process? (A Social Work Captain consulting with a Major or Lieutenant would be considered a "rank difference.") 15

a. _____ significant effect (1)
b. _____ moderate effect (2)
c. _____ slight effect (3)
d. _____ no effect (4)

38. If you answered "a", "b", or "c" in question #37, do you think the effects are usually beneficial or detrimental to the consultation process? 16

a. _____ highly beneficial (1)
b. _____ somewhat beneficial (2)
c. _____ somewhat detrimental (3)
d. _____ highly detrimental (4)

39. To what degree have you experienced rank differences in your practice of command consultation? (Answer for all three instances.)

	NEVER	RARELY	OCCASIONALLY	OFTEN	FREQUENTLY	
a. When I held a lower rank than my consultees	____	____	____	____	____	17
b. When I held a higher rank than my consultees	____	____	____	____	____	18
c. When I held equal rank to my consultees	____	____	____	____	____	19

40. In considering my overall experiences with command consultation, I feel that my most effective consultations have occurred when I... 20

a. _____ held less rank than my consultees. (1)
b. _____ held higher rank than my consultees. (2)
c. _____ held equal rank to my consultees. (3)
d. _____ My most effective consultation were equally divided among all of my consultees, regardless of rank. (4)

41. The following items have been considered by some Army social workers to interfere with the successful implementation of command consultation programs. Read each item and indicate the degree to which you think it may interfere with command consultation activity. In the spaces provided, write the following numbers:

"4" if the item <u>strongly interferes</u>.
"3" if the item <u>moderately interferes</u>.
"2" if the item <u>slightly interferes</u>.
"1" if the item <u>never interferes</u>.

a. _____ Command consultation is complex and difficult to do. 21
b. _____ Frequent assignment rotation of staff disrupt continuity. 22
c. _____ Staff feel a stronger committment to working with the individually troubled soldier than with consulting with commanders. 23
d. _____ The rewards of command consultation are not readily observeable. 24
e. _____ It is threatening to consult with higher ranking commanders. 25
f. _____ Doing consultation is elitist in nature. 26
g. _____ Unwillingness of commanders to use consultation services. 27
h. _____ Limited experience of mental health personnel doing consultation. 28
i. _____ Bureaucratic, organizational constraints. 29
j. _____ Command consultation is not consistent with the traditions of social work practice. 30
k. _____ Other (please specify): _____

42. To what extent do you value each of the following reasons for practicing command consultation? Write in the spaces provided the following numbers:

"4" if you value the reason very highly.
"3" if you value the reason somewhat highly.
"2" if you value the reason moderately.
"1" if you value the reason slightly.

a. _____Best use of manpower and personnel. 31
b. _____Cuts down on referrals to the Mental Hygiene Service. 32
c. _____Familiarizes commanders with new knowledge or different perceptions of a problem, and thereby enables them to more effectively help troubled soldiers. 33
d. _____Prevents social dysfunction. 34
e. _____Maximizes effectiveness in the total organization. 35
f. _____Helps to break down stigma associated with mental health problems. 36
g. _____Most efficient means of helping the individual. 37

43. Have there been sufficient opportunities for Army social workers to test out command consultation so that if it were of appeal or value, they could then adopt the practice more extensively? *76

a. _____yes (1)
b. _____no (2)

STATEMENT:

The following questions concern the status of Army social work and the resultant relationship with the development of command consultation.

44. During the time periods listed below, what levels of professional status do you think Army social work had achieved in relation to psychiatry? (Answer for those time periods for which you have knowledge.)

	SIGNIFICANTLY HIGHER STATUS	SOMEWHAT HIGHER STATUS	EQUAL STATUS	SOMEWHAT LOWER STATUS	SIGNIFICANTLY LOWER STATUS	
a. Early 1950's	____	____	____	____	____	38
b. Late 1950's	____	____	____	____	____	39
c. Early 1960's	____	____	____	____	____	40
d. Late 1960's	____	____	____	____	____	41
e. 1970's	____	____	____	____	____	42

45. What impact do you think the development of command consultation activity had on the professional status of Army social work?

Army social work's professional status was...

	GREATLY ENHANCED	SOMEWHAT ENHANCED	UNAFFECTED	SOMEWHAT DIMINISHED	GREATLY DIMINISHED	
a. Early 1950's	____	____	____	____	____	43
b. Late 1950's	____	____	____	____	____	44
c. Early 1960's	____	____	____	____	____	45
d. Late 1960's	____	____	____	____	____	46
e. 1970's	____	____	____	____	____	47

46. Was Army social work__administratively - professionally__subordinate to psychiatry during the following time periods?

	ADMINISTRATIVELY SUBORDINATE		PROFESSIONALLY SUBORDINATE		
	YES	NO	YES	NO	
a. Early 1950's	___	___	___	___	48 53
b. Late 1950's	___	___	___	___	49 54
c. Early 1960's	___	___	___	___	50 55
d. Late 1960's	___	___	___	___	51 56
e. 1970's	___	___	___	___	52 57

47. If you answered "yes" in any part of question # 46, please mark your reaction in each instance:

	If social work were...				
	ADMINISTRATIVELY SUBORDINATE		PROFESSIONALLY SUBORDINATE		
	I found this to be...				
	ACCEPTABLE	UNACCEPTABLE	ACCEPTABLE	UNACCEPTABLE	
a. Early 1950's	___	___	___	___	58 63
b. Late 1950's	___	___	___	___	59 64
c. Early 1960's	___	___	___	___	60 65
d. Late 1960's	___	___	___	___	61 66
e. 1970's	___	___	___	___	62 67

48. Have you ever been called a "junior psychiatrist." 68

a.____yes (1)

b.____no (2)

49. How do you react to this term? 69

a.____I find this term acceptable. (1)

b.____I find this term unacceptable. (2)

50. The development of command consultation tended to: 70

a.____make social work more subordinate to psychiatry. (1)

b.____make social work less subordinate to psychiatry. (2)

c.____have no effect on the association between social work and psychiatry. (3)

51. The relationship between social work and psychiatry tended to: 71

a.____encourage the development of command consultation. (1)

b.____inhibit the development of command consultation. (2)

c.____have no effect on the development of command consultation.. (3)

52. Which discipline in the mental hygiene programs assumed the more active role with regard to the actual practice of command consultation? 72

a.____psychology (1)

b.____social work (2)

c.____psychiatry (3)

53. In the settings of the mental hygiene programs of the Army, do you think that the relationship between social work and psychiatry was significantly altered when social work achieved separate service in the later half of the Sixties? 73

a.____yes (1)
b.____no (2)
c.____no knowledge of this event. (3)

54. Gaining the status of a separate service had the following effect: 74

a.____It gave social work greater independence from psychiatry. (1)
b.____It made social work more heavily reliant on psychiatry. (2)
c.____It had no effect on the relationship between social work and psychiatry. (3)
d.____No knowledge of this event. (4)

55. The achievement of separate service status had the following effect on Army social work involvement in command consultation. 75

a.____Command consultation activity increased. (1)
b.____Command consultation activity decreased. (2)
c.____Command consultation activity remained the same. (3)
d.____No knowledge of this event. (4)

* * * * * *

STATEMENT:

This section of the questionnaire asks about the extent to which you believe that command consultation practice has been formally and officially integrated into the established organizational structure of Army social work.

56. To your knowledge, did the Department of the Army ever give official support and sanction to the practice of command consultation? C.5 11

a.____yes (1)
b.____no (2)
c.____do not know (3)

57. Are there specific Army regulations which provide an official mandate for the practice of command consultation? 12

a.____yes (1)
b.____no (2)
c.____do not know (3)

58. Psychiatry, social work, and psychology consultants to the Surgeon General conduct a variety of activities in helping to spread the idea and encourage the practice of command consultation. How do you rate the value of their activities? In the spaces, write the number...

"4" if the activity is HIGHLY BENEFICIAL.
"3" if the activity is MODERATELY BENEFICIAL.
"2" if the activity is SLIGHTLY BENEFICIAL.
"1" if the activity is NOT BENEFICIAL.

a.____Visits to local mental health services such as the MHCS. 13
b.____Preparation of newsletters, bulletins, etc. 14
c.____Writing policy 15
d.____Maintaining frequent phone contact with social work chiefs. 16
e.____Supporting and encouraging research. 17
f.____Assigning specialized personnel to appropriate slots. 18
g.____Programming professional conferences with command consultation content. 19
h.____other, please specify:

59. To what extent have the training manuals explained command consultation practice? 20

a. _____They have said nothing about command consultation. (1)

b. _____They have briefly mentioned command consultation. (2)

c. _____They have explained the principles of command consultation. (3)

d. _____They have largely defined and clarified the techniques and practice of command consultation. (4)

e. _____I do not know what they have said about command consultation. (5)

60. During the following time periods, what emphasis do you think has been given to command consultation topics at Army social work conferences or multi-disciplined professional meetings?

	STRONG EMPHASIS	MODERATE EMPHASIS	WEAK EMPHASIS	NO EMPHASIS	
a. Early 1950's	___	___	___	___	21
b. Late 1950's	___	___	___	___	22
c. Early 1960's	___	___	___	___	23
d. Late 1960's	___	___	___	___	24
e. 1970's	___	___	___	___	25

61. Do you think that knowledge about the availiability of command consultation services has been effectively communicated to recipients of these services, namely consultees? 26

a. _____yes (1)

b. _____no (2)

62. The following list of items are some ways by which commanders learn about the existance of command consultation services.

In Column #1: Designate the ways in which you think commanders <u>have most often learned</u> about command consultation. (Do so by giving a number "1" for the most often, a number "2" for the second most often, etc. Rank all seven (7) items.)

In Column #2: Indicate the ways in which commanders <u>should most often learn</u> about command consultation. (Repeat as in Column #1 by giving a number "1" for the most often, etc. Rank all items.)

	Column #1 WAYS COMMANDERS *HAVE* LEARNED	Column #2 WAYS COMMANDERS *SHOULD* HAVE LEARNED	
a. Post newspaper or publications.	_____	_____	27 28
b. Local directives, circulars or regulations	_____	_____	29 30
c. Briefing from battalion or brigade commanders	_____	_____	31 32
d. Informal discussion with fellow company commanders	_____	_____	33 34
e. Formal presentations by mental hygiene staff.	_____	_____	35 36
f. Informal contact or exposure to mental hygiene staff	_____	_____	37 38
g. Department of Army communications (Circulars, AR's, training bulletins, etc)	_____	_____	39 40
h. other (please specify) _____	_____	_____	41 42

63. Check the one (1) statement which you feel is most accurate: 43

a. ___ The published literature on command consultation is substantial. (1)

b. ___ There is an average selection of writing on command consultation. (2)

c. ___ There is a minimal amount of material written on command consultation. (3)

d. ___ There is virtually nothing written on the subject. (4)

e. ___ I do not know what has been written on command consultation. (5)

64. If you answered either a - b - c in question #63 above, what do you believe is the quality of this literature? 44

a. ___ very high quality (1)

b. ___ somewhat high quality (2)

c. ___ somewhat low quality (3)

d. ___ very low quality (4)

65. How familiar have you been with with non-military literature that deals generally with techniques, theory or practice of consultation? 45

a. ___ highly familiar (1)

b. ___ somewhat familiar (2)

c. ___ somewhat unfamiliar (3)

d. ___ highly unfamiliar (4)

66. I feel that formal provisions for teaching new Army social workers about command consultation have been... 46

a. ___ abundant (1)

b. ___ sporadic (2)

c. ___ virtually non-existent (3)

67. The items below are factors which often influence whether or not a command consultation program will be initiated or maintained.

In Column #1: rank all four items assigning the number #1 to the factor you feel has had the strongest influence, the number #2 to the factor which has had the second strongest influence, etc.

In Column #2: rank all four items assigning the number #1 to the factor you feel that should have had the strongest influence, the number #2 to the factor that should have had the second strongest influence, etc.

(RANK FROM #1 thru #4)	Column #1 INFLUENCE THAT THE ITEM HAD	Column #2 INFLUENCE THAT THE ITEM SHOULD HAVE HAD	
a. The personality and/or ability of the mental health personnel, particularly the chief.	____	____	47 51
b. The needs of the local post or community.	____	____	48 52
c. Established policy and/or regulations.	____	____	49 53
d. Available resources, i.e. manpower workload, etc.	____	____	50 54

* * * * * *

IDENTIFYING INFORMATION:

68. Age at last birthday: _____ years of age. 55-56

69. Sex: a. _____ male b. _____ female 57

70. In what year did you receive your MSW degree? 19_____ 58-59

IDENTIFYING INFORMATION (continued)

71. Indicate your highest level of education: 60

a._____Masters degree (1)

b._____Some Post Masters work (specify)_____ (2)

c._____Doctoral degree (specify)_____ (3)

72. Indicate the emphasis of your study sequence in social work graduate school: 61

a._____Casework (1)

b._____Group Work (2)

c._____Community Organization (3)

d._____Generalist or generic (4)

e._____other (5)

73. Prior to entering the Army social work program, did you have an academic familiarization with the general principles of consultation? 62

a._____yes b._____no (1-2)

74. Prior to entering the Army social work program, did you ever practice consultation in civilian social work settings? 63

a._____yes b._____no (1-2)

75. If you are no longer in the Army social work program, and if you practice social work in a civilian setting, have you done any consultation? 64

a._____yes b._____no c.____not applicable (1-2-3)

76. If you answered "yes" to question #75 above, do you find the general principles and practices of consultation in civilian settings to be... 65

a._____very different from consultation in the military. (1)

b._____somewhat different from consultation in the military. (2)

c._____somewhat similar to consultation in the military. (3)

d._____very much similar to consultation in the military. (4)

77. Indicate the number of papers or articles you wrote which were specifically about command consultation. 66

a._____none (1)

b._____one (2)

c._____two to four (3)

d._____five or more (4)

78. Indicate the number of papers or articles you wrote which broadly related to mental hygiene, Army social work, civilian social work, etc. 67

a._____none (1)

b._____one (2)

c._____two to four (3)

d._____five or more (4)

79. Check the statement which applies to you: 68

a._____I have not usually attended conferences (1)

b._____I have occasionally attended conferences (2)

c._____I attended conferences whenever I have had the opportunity. (3)

30. Identify the inclusive dates in which you served in the Army social work program: 69-72

(from)_____ (to)_____

81. Did you have non-social work military service? 73

a.____yes b.____no (_)(1)

82. If you answered yes to question #81 above, complete this question:

a. Were you...

(1)___a field grade officer? (2)

(2)___a company grade officer? (3)

(3)___a warrant officer (4)

(4)___a senior NCO (5)

(5)___a FPC or junior NCO (6)

b. What were the dates of this non-social work military service? 74-75 c.6 11-12

(from)_____ (to)_____

c. Identify the nature of this service. (Example: Aviator, infantryman, Naval supply officer, medic, etc. 13-14

83. What is the total number of years you had as an Army social worker? 15-16

_____years

84. What is your present status? (check one) 17

a.____active duty in Army social work program (1)

b.____retired military with 20 or more years service (2)

c.____civilian without military retired status (3)

d.____other (specify)_____ (4)

85. Indicate the highest rank you have held: 18

a.____1st or 2nd Lieutenant (1)

b.____Captain (2)

c.____Major (3)

d.____Lieutenant Colonel (4)

e.____Colonal (5)

86. Did you think any question unclear, ambiguous, or otherwise difficult to deal with? Identify and expiain the problem you had. 19-20

87. Has the questionnaire adequately tapped the reality of your experiences with command consultation? 21

a.____yes (1)

b.____no (2)

Please use the blank sheet at the end of the questionnaire to elaborate on any additional aspect of your experiences which you feel relevant to this study. 22

88. How long did it take you to complete the questionnaire? 23

_____hour(s) _____minutes

THANK YOU FOR YOUR TIME AND YOUR GENEROUS CONTRIBUTION!

COMMENTS

APPENDIX D

SCREENING SURVEY

406-B Murray Avenue
Fort
17 July 1974

Dear Social Work Colleague:

I am currently conducting a research project on the command consultation function in the United States Army Social Work Program. This project is supported by the Medical Research and Development Command and is one of the requirements of my social work doctoral degree at Yeshiva University.

I obtained your name and address from a roster of US Army Reserve Officers, and I am writing to you to determine if you are knowledgeable about command consultation and to assess whether or not your experience would be of further value to the conduct of my study. I would appreciate if you would complete the questions below and return it to me in the enclosed postage free envelope within 48 hours. Your answers will be seen only by myself in order to maintain strict confidentiality.

Sincerely,

Paul F. Brenner

Paul F. Brenner, Cpt. MSC
United States Army
Social Work Doctoral Student

PLEASE ANSWER EACH ITEM

---

1. When were you on active duty in the Army Social Work Program?

   From: _____ (month) _____ (year) To: _____ (month) _____ (year)

2. Have you ever heard of the term "command consultation"?

   a. ____yes b. ____no

3. How do you rate your knowledge of command consultation?

   a. ____no knowledge b. ____some knowledge c. ____full knowledge

4. Did you ever practice command consultation?

   a. ____yes b. ____no

5. Did you know other colleagues who practiced command consultation?

   a. ____yes b. ____no

6. Can you explain command consultation?

   a. ____yes b. ____no
   If yes, please use reverse side of page to define or identify your understanding of what constitutes command consultation.

7. What is your current mailing address and telephone number?

(If you wish to elaborate on any question, use reverse!)

APPENDIX E

EXAMPLE OF A REQUEST BY A PRACTITIONER SEEKING INFORMATION ABOUT COMMAND CONSULTATION

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY QUARTERMASTER CENTER AND FORT LEE
FORT LEE, VIRGINIA 23801

ATZM-PA-AD

8 March 1975

Captain Paul Brenner
School of Social Work
Yeshiva University
New York City, New York

Dear Captain Brenner:

Major Greg Meyer suggested I write to you regarding the topic of command consultation. I am currently trying to motivate my staff to conduct unit visits, consult with commanders and NCO's, and to view the unit as a client system which can be changed instead of the "impediment" to rehabilitation efforts. I am meeting with limited success, and am constantly looking for new ammunition.

I would appreciate any information you have on the subject to include bibliographies, references, or names of consultants who might be willing to put on a workship at Fort Lee. Even a phone call would be appreciated (804) 734-2804, AUTOVON 687-2804.

Thank you.

Sincerely,

James F. Loomis

JAMES F. LOOMIS, MSW
1LT, GS
Alcohol Drug Control Officer

APPENDIX F

EXAMPLE OF A COMMAND CONSULTATION STAFF DEVELOPMENT PROGRAM

DISPOSITION FORM

(AR 340-15)

REFERENCE OR OFFICE SYMBOL	SUBJECT
AHBOMS-SW	Staff Development Program

TO	FROM	DATE	CMT 1
All Social Work Officers MAJ. d'Orazio	Captain Davis	3 March 1969 CPT Davis/mm/2938	

1. The topic for discussion at this weeks Staff meeting is consultation: As a Social Work Method and it's application in a Military Setting.

2. The format will be to read the attached summary, formulate questions and answers, and be prepared to discuss the summary and the question areas listed below.

a. What is consultation?
b. Is there one acceptable definition?
c. What are the requirments for a consultant? (Education and experience).
d. What are the objectives of consultation?
e. What is the role of the consultant? Consultee?
f. What are some of the problems in these roles?
g. What methods does the consultant use?
h. Are services always requested?
i. Is part of the consultee role expectations that he accept consultant's findings?
j. What responsibilities (if any) does the consultant have for follow-up?
k. When should services be terminated.
l. Is consultation an acceptable social work method?
m. Is the command consultation program consultation as defined by Social Work? If not, why not?
n. What special considerations must be taken by the "Command Consultant"?
o. (see attached)

King E. Davis

KING E. DAVIS
CPT, MSC
Asst Chief, Social Work Service

SOME CHARACTERISTICS AND CONSIDERATIONS

1. An adequate definition of consultation has not yet evolved (Gorman) nor have it's characteristics been the subject of systematic analyses.

2. A primary goal is to indirectly influence the services provided clients and secondarily to enable consultee to be more effective in handling similar problems in the future.

3. Consultation shares many of the features of other problem solving methods.

4. Consultation carries an educational component.

5. The consultant has responsibility for assessing the areas in which he is equipped to give consultation.

6. The consultee is ethically bound to make every effort to use the outcome of the consultation (Werner Boehm)

7. The consultee is free to accept or reject consultation or utilize it as he will. (Mary Gilmore)

8. Consultation requires 1) an indirect service activity, 2) a voluntary, coordinate relationship, 3) tack-oriented, 4) makes knowledge, experiences, and professional attitudes available to others.

9. Consultant can be frank, objective, understanding and bring new concepts and skills to new problems.

10. Areas for consultation include 1) professional work, 2) relationships, 3) obtaining funds, 4) general operations, 5) records, 6) administration, 7) methods.

11. Consultation process involves establishing and maintaining good relationships, starting where person is, ability to asses need to feeling, helps person state problem, builds on strengths, paced to needs of consultee.

12. Consultation should be accepted by total agency as having a place in it's program.

13. Structures must be set up to facilicate consultation and administration support and sanction given to it.

14. Problems: transition from practitioner to consultant; professional identity; and professional status.

SUMMARY

Consultation is a valid social work function. It is conceived of as an activity which in essence is concerned with problem-defining and problem-solving. It is different from other social work problem-solving activities. In the spectrum of social work methods and services, it is characterized as an indirect service which can be grouped with other activities that are geared to staff and program development. The purpose of consultation is to introduce change in some facet of the consultee system. Thus, the consultant role may be viewed as that of change agent. The more immediate goal of consultation is to strengthen consultees in their designated professional role. The content of consultation may be focused on cases, policy, or program. It may be directed at staff on any level of the administrative hierarchy. Consultation takes place through a transactional process in which help is given with work problems and in which some technical knowledge, relevant to the problem under examination, may be transmitted. The consultant carries a staff rather than line function, and thus has no administrative authority over the outcome of the work. His authoirty rests on his status as expert and on the administrative sanction which allows him to enter the consultee system. The consultant role requires some degree of distance from the system of the consultee, as well as a fair degree of autonomy. Consultation may be carried out either through individual or group methods. The consultant carries multiple roles and functions, congruent with the consultation role, but not all of which are consultation activities. This, therefore, requires constant clarification during the negotiation and maintenance of the consultation contract. Consultation, furthermore, is viewed as a time-limited, goal-oriented, and segment-focused transaction. Its purposes and its results need to be reviewed and evaluated periodically. The consultation role may be assumed without any special preparation, but increasingly, as the field describes and conceptualized its practice, and as the body of knowledge grows, more formal patterns of education will emerge to give substance and sophistication to this area of social work practice.

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